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	15G245	A. BUILDING 00 B. WING	05/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	4378 FOURTEENTH LN HOBART, IN 46342

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W000000	This visit was for an extended annual recertification and state licensure survey to a full survey (Client Protections, Healthcare Services and Governing Body). This visit resulted in an Immediate Jeopardy. Dates of Survey: 5/7, 5/8, 5/9, 5/10, 5/13, 5/14, 5/15, 5/16, 5/17 and 5/20/13 Facility Number: 000768 Provider Number: 15G245 AIMS Number: 100234520 Surveyors: Paula Chika, QIDP-TC Amber Bloss, QIDP Christine Colon, QIDP (5/13/13 to 5/20/13) These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/20/13 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 2 sampled clients (#1 and #2). The governing body failed to ensure client #1 and #2's heath care needs were met and not neglected. The governing body failed to ensure the facility's nursing services trained staff in regard to diabetes/a diabetic diet, and to ensure staff administered medications according to the physician's orders. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations in regard to client to client aggression/abuse for client #2. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 of 4 sampled clients (client #1). The governing body failed to implement its written policies and procedures to prevent neglect of an insulin dependent client. The governing body failed to ensure the facility developed a consistent risk plan to address client #1's diabetes. The	W000102	W 102 Governing body see w122 and 104	06/01/2013

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	governing body failed to develop menus with dietary guidelines for staff regarding the client's physician ordered diet. The governing body failed to ensure staff were trained on the signs and symptoms of client #1's diabetes as related to hypo-glycemia and hyper-glycemia. The governing body failed to ensure the facility aggressively addressed the client's refusals of appointments and labs to prevent recurrence of hospitalizations/health risks associated with the client's diabetes. The governing body also failed to implement its policy and procedures to prevent neglect of client #2 due to a significant weight loss. Please see W122. 2. The governing body failed to meet the Condition of Participation: Health Care Services for 2 of 2 sampled clients (#1 and #2). The governing body failed to ensure the facility's Health Care Services met the nursing needs of the clients it served. The governing body failed to ensure its Health Care Services assessed, monitored and/or addressed a client's health care needs in regard to diabetes, and failed to ensure facility staff were trained in regard to diabetes and following a diabetic diet. The governing body failed to ensure its Health Care Services contacted client #1's doctor in regard to low and/or high blood sugar			

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	levels. The facility's governing body failed to ensure needed risk plans were developed for clients #1 and #2. The governing body failed to ensure the facility's Health Care Services ensured medications for client #1's diabetes were administered as ordered. 3. The governing body failed to ensure the facility implemented its written policies and procedures to prevent neglect and/or potential harm in regard to Client #1's diabetes. The governing body failed to ensure the facility specifically addressed/developed a risk plan for the client's diabetes. The governing body failed to ensure the facility developed a diabetic menu for facility staff to follow/implement, and to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The governing body failed to ensure facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The governing body failed to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The governing body failed to aggressively address the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The governing			

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	body failed to implement its written policy and procedures to prevent neglect of client #2 in regard to loss of weight. The governing body failed to ensure the facility investigated allegations of client to client abuse involving client #2 at the facility's owned day program. The governing body failed to ensure its Health Care Services specifically addressed/developed a risk plan for client #1's diabetes. The governing body failed to ensure the nursing services obtained a diabetic menu for facility staff to follow/implement, and failed to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The governing body failed to ensure the nursing services monitored client #1's diabetes on a more frequent basis and notified the physician as indicated in the client's program plan. The governing body failed to ensure facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The governing body failed to ensure nursing services developed a risk plan for client #1's Urinary Tract Infection (UTI) and/or, failed to monitor and/or develop a risk plan for client #2's weight loss.			

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	The governing body failed to ensure its Health Care Services trained staff in regard to diabetes and diabetic menu required to meet the health needs of Client #1. The governing body failed to ensure medications were administered per the physician's orders for client #1. Please see W104. 9-3-1(a)			

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 2 sampled clients (#1 and #2), the governing body failed to exercise general policy and operating direction over the facility to ensure client #1 and #2's heath care needs were met and not neglected. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services trained staff in regard to diabetes/a diabetic diet, and to ensure staff administered medications according to the physician's orders. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted investigations in regard to client to client aggression/abuse for client #2. Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policies and procedures to prevent neglect and/or potential harm in regard to Client #1's diabetes. The governing body failed to exercise general policy and operating	W000104	W 104 Governing body see W149 and W154, W331, W342, W368	06/01/2013

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	direction over the facility to ensure the facility specifically addressed/developed a risk plan for the client's diabetes. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility developed a diabetic menu for facility staff to follow/implement, and to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility aggressively addressed the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of client #2 in regard to loss of weight.			

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	Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to investigate allegations of client to client abuse involving client #2 at the facility's owned day program. Please see W154. 3. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health care Services specifically addressed/developed a risk plan for client #1's diabetes. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services obtained a diabetic menu for facility staff to follow/implement, and failed to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services monitored client #1's diabetes on a more frequent basis and notified the physician as indicated in the client's program plan. The facility's governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services ensured facility staff reported client #1's low and			

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	high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services developed a risk plan for client #1's Urinary Tract Infection (UTI) and, failed to monitor and/or develop a risk plan for client #2's weight loss. Please see W331. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services trained staff in regard to diabetes and diabetic menu required to meet the health needs of Client #1. Please see W342. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's Health Care Services administered medications per the physician's orders for client #1. Please see W368. 9-3-1(a)			

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview, and record review, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (client #1). The facility failed to implement its written policies and procedures to prevent neglect of an insulin dependent client. This non-compliance resulted in an Immediate Jeopardy as the facility neglected to develop a consistent risk plan to address client #1's diabetes. The facility neglected to develop menus with dietary guidelines for staff regarding the client's physician ordered diet. The facility neglected to train staff on the signs of symptoms of client #1's diabetes as related to hypo-glycemia and hyper-glycemia. The facility neglected to aggressively address the client's refusals of appointments and labs to prevent recurrence of hospitalizations/health risks associated with the client's diabetes. The Immediate Jeopardy began on 4/19/2013 at 3:45 PM and was identified on 5/09/13 at 7:00 PM. The Director of Community Services, Community Services Operations Director, Behavioral Health Director, Volunteer Services Coordinator, Director of Health Care Services, and the	W000122	Client protectionThe client was taken to the ER on 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was given on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to high reading, signs symptoms and response to low readings, notifying the community services nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and	06/01/2013

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	Executive Director were notified of the of the Immediate Jeopardy on 5/10/13 at 12:15 PM. The facility submitted a plan for removal of the Immediate Jeopardy on 5/15/13 at 6:01 PM. The facility's plan of action/removal indicated client #1 would be taken to the doctor on 5/14/13 to "acquire a full medical assessment including any needed labs and written doctors orders as to the management of client's diabetes including but not limited highs and lows, specific sliding scale and routine insulin instructions/administration, when to notify the physician, signs, symptoms of hyper and hypoglycemia and the use of the Glucerna specifically to this client's needs...." The facility's plan indicated client #1's risk plan would be revised to "...reflect the information received from the physician...." The facility's plan of removal indicated facility staff would fax client #1's blood sugar levels to the nurse once a day. The plan indicated a journal would be implemented by 5/11/13 "...to include blood sugar readings, and interventions, intake and applicable behavioral observations. The community services nurse will review this journal weekly. Any reading outside of the risk plan's definition will result in additional training of staff until such time that the plan is appropriately implemented. The service coordinator will monitor that the		hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.In order to prevent reoccurrence all staff will be trained on the risk plan, this training will include demonstration of reading blood sugars, administering insulin injections via flex pen and use of the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again on 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff was trained on it 5/9/13 and it was implemented on 5/10/13– which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The community services nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A search for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addition, the use of electronic MARS will be investigated with upcoming new software.Until such time that	

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	nursing staff is receiving this information in a timely manner through weekly audits of the information for three months and then monthly thereafter...." The 5/15/13 plan indicated a release of information form would be sent to the hospital upon discharge of clients. The plan indicated the facility's nurse would obtain this information within 48 hours of discharge "...or when lab results have been completed...." The plan indicated if the nurse did not obtain the information, the Service Coordinator would go to the hospital to obtain the information. The facility's plan of removal indicated facility staff would be trained on the revised risk plan on 5/21/13. The plan indicated "...If any new staff is assigned to the home the Area manager will refer the staff for training prior to working at the home. Training will include demonstration of reading blood sugars, drawing injections and use of the sliding scale (if applicable). The area manager will audit the training records of all staff that work at this home on a monthly basis for three months, she will audit new staff's training records within 90 days of employment thereafter." The risk plan indicated the nutritionist would train day service and group home staff on 5/21/13. The plan also indicated the nutritionist would develop an 1800 calorie diabetic menu. The risk plan indicated the nutritionist would visit the		the staff has shown competency in the skills, the nurse will continue to do observations at the home daily. Once competency has been demonstrated, the frequency of visits will decrease to every other day for two weeks then weekly for one month and monthly thereafter.Nursing staff trained staff on existing diabetic diets on 5/9/13 (these plans were not at the home at the time of the survey). As orders have changed and risk plans revised. Additional trainings will be provided. The nutritionist to make a home visit and develop sample 1800 calorie diabetic menus as guidelines for menu development by 5/22/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home within 2 weeks and will observe a meal and document her observations. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the	

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	home within 2 weeks and observe a meal. The risk plan indicated a behavior plan would be developed to address the client's refusals of labs and medical assessments by 5/28/13. Based on observation, interview and record review of the facility's 5/15/13 letter of removal, it was determined the facility's plan of action had not removed the Immediate Jeopardy and the Immediate Jeopardy continued because the facility needed to still train staff in regard to client #1's diabetic diet as the dietician would not be at the facility until 5/20/13 to train staff. The facility still needed to obtain an 1800 calorie diabetic diet menu, including a list of snacks for client #1. The facility also needed to update client #1's risk plan to match the client's changes in insulin order, and to ensure the facility's nursing services monitored client's blood glucose levels on a more frequent basis, as the plan did not indicate how often the facility's nurse would be in the group home to monitor the client. The facility still needed to develop a plan which addressed client #1's refusals in regard to medical appointments/tests. The facility's plan of removal did not specifically indicate how the facility would ensure staff would be adequately trained prior to working in the home. The facility still needed to		Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. Finally, Client #1 continues to see his doctor and specialist. His risk plan will be modified following each visit as necessary and will be distributed to the home and day program with additional training as needed.Please see W 149 and W 154 for additional planning	

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	implement and monitor its plan of correction/removal, over a period of time, to ensure its effectiveness to meet the health care needs of the client. During the 5/13/13 observation period between 5:10 PM and 6:15 PM, at the group home, client #1 ate dinner which consisted of 1 breaded fish patty, 18 tater tots, approximately 1 cup of mixed vegetables (corn, green beans and carrots), milk and water. No 1800 calorie diet menu was posted and/or present in the group home. Interview with staff #6 and #7 on 5/13/13 at 6:15 PM indicated no 1800 calorie specific diet had been submitted for client #1. Staff #6 and #7 indicated they were instructed to document what client #1 ate. During the 5/14/13 observation period between 10:30 AM and 11:45 AM, at the day service program, there was no 1800 calorie diet menu at the day service program. Client #1 was at a doctor's appointment concerning the client's diabetes. Client #1's record was reviewed on 5/14/13 at 10:30 AM. Client #1's May 2013 Medication Administration Record (MAR) indicated client #1's blood sugar level on 5/14/13 was 319. Interview with the Health & (and) Safety Tech (HST) on 5/14/13 at 10:45 AM indicated the facility sent a communication book which the			

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	group home and day service staff were to document in on what client #1 ate at the day service program. The HST indicated the day service staff had not been trained in regard to the client's diet, diabetes and carbohydrate exchange. Interview with the food service staff #2 on 5/14/13 at 10:58 AM stated "There was no special diet for [client #1]. He is given the same diet as all the other clients." Food service staff #2 stated the day service staff was told to give client #1 extra water "since he is always thirsty." The Day Program Director was interviewed on 5/14/13 at 11:40 AM. The Day Program Director indicated day program staff had not been trained in regard to the menus submitted for the day program. The Day Program Director stated client #1 was given "The [name of company] juice with sugar and drinks throughout the day because "He is always thirsty." During observations on 5/15/13 between 3:50 PM and 4:30 PM, at the day program, the day program did not have an 1800 calorie diet menu. Client #1's diet sheet indicated client #1 consumed a "pretzel with cheese, potato chips, 1 cup of water, 1 can of Glucerna, 1 cookie, 1 pudding and diluted apple juice." Interview HST #2 on 5/15/13 at 4:10 PM indicated client #1's doctor had discontinued the sliding scales and testing			

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	client #1's blood sugar level before lunch. The HST indicated the communication book which was to come back and forth between the day service program and the group home, was not sent in on 5/15/13. During the 5/15/13 observation period between 4:45 PM and 5:30 PM at the group home, there was no 1800 calorie diet menu posted/present in the group home for staff to follow. Interview with staff #6 and #7 on 5/15/13 at 4:50 PM indicated the menus had not been submitted, and no training had occurred. Staff #6 and #7 indicated they were told to discontinue testing client #1's blood glucose levels before meals and to discontinue the client's sliding scale injections. Staff #6 and #7 indicated client #1 received 15 units of insulin in the morning and at bed time. Client #1's record was reviewed on 5/16/13 at 9:55 AM. Client #1's 5/14/13 Medication Change Form indicated indicated "Continue with Novolog mix 70/30 AM. PM.(sic) Test blood sugar before breakfast. Give 15 units of Insulin sub (subcutaneous) before he eats. Hold insulin if blood sugar is under 70 and call nurse. Test blood sugar before dinner. Give 15 units of Insulin sub Q before he eats. Hold insulin if blood sugar is under 70 and call nurse. Call nurse if B/S (blood			

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	sugar) is more than 300." The 5/14/13 sheet indicated client #1's sliding scale insulin and blood sugar checks at lunch and bedtime were discontinued. Client #1's 1800 ADA Calorie Diet exchange sheet indicated facility staff were documenting what client #1 ate. Client #1's 5/15/13 exchange sheet indicated the day service staff documented "*No Binder sent in today with consumer." Client #1's 5/9/13 Diabetic Plan indicated staff would be trained on an 1800 calorie diet. The risk plan indicated staff were to encourage client #1 to choose "healthy food choices." The plan indicated staff would be trained on blood sugar monitoring, and client #1's blood sugar levels would be taken 4 times a day. The plan indicated if client #1's blood sugar was below 70 staff were to check the client for symptoms of Hypoglycemia as indicated by the following: "-Hunger -Sweating -Confusion -Shakiness -Dizziness -Anxiety -Nervousness -Sleepiness -Weakness			

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	-[Client #1] may also pull himself into a fetal position/curled into a ball." The plan indicated staff were to monitor for these symptoms throughout the day, and to test the client's blood sugar when symptoms present. The 5/9/13 risk plan indicated if the client's sugar was low the staff were to offer the client orange juice, pop, cookies, milk, "Glucose Gel/Gel Icing" and/or cake frosting. The risk plan also indicated if client #1's blood sugar level was above 200 staff should monitor/check the client for "-Frequent urination -Fatigue -Abdominal Pain -Dry Mouth -Increased thirst -Headache -Nausea and Vomiting -Weakness -blurred vision -Fruity Smelling breath -Shortness of Breath -Confusion -Coma -[Client #1] may also pull himself into a fetal position into a ball." The risk plan indicated "If [client #1's] blood sugar is above 300 encourage him to drink water, call the nurse. Retest in one hour. If it is still above 300 call 911. If [client #1] is sick and not able to keep fluids down And his blood sugar is above 300 mg/dl Call			

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	911 and then the nurse. If [client #1's] sugar is above 400 encourage him to drink water and Call 911 and then the nurse...." The 5/9/13 risk plan indicated "...A journal is to be sent from home to the day program and returned each day. Staff are to document his blood sugar reading, number of units, and what he consumed. Each Monday a this (sic) journal is to be sent to the community services nurse. A new journal is to be initiated....." The Immediate Jeopardy was not removed. Based on observation, interview and record review for 1 of 2 sampled clients, (#2), the facility neglected to implement its written policy and procedures to prevent neglect of the client in regard to weight loss. Findings include: 1. The facility neglected to implement its written policies and procedures to prevent neglect and/or potential harm in regard to Client #1's diabetes. The facility neglected to specifically address/develop a risk plan for the client's diabetes. The facility neglected to develop a diabetic menu for facility staff to follow/implement, neglected to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic			

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	diet. The facility neglected to ensure facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The facility neglected to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The facility neglected to aggressively address the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. The facility also neglected to implement its written policy and procedures to prevent neglect of client #2 in regard to loss of weight. Please see W149. 2. The facility failed to investigate allegations of client to client abuse involving client #2 at the facility's owned day program. Please see W154. 9-3-2(a)			

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review, and interview for 1 of 2 sampled clients (#1), the facility neglected to implement its written policies and procedures to prevent neglect and/or potential harm in regard to the client's diabetes. The facility neglected to specifically address/develop a risk plan for the client's diabetes. The facility neglected to develop a diabetic menu for facility staff to follow/implement, neglected to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The facility neglected to ensure facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The facility neglected to ensure the facility's nursing services monitored the client's diabetes on a more frequent basis. The facility neglected to aggressively address the client's refusals of appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes. Based on observation, interview and record review for 1 of 2 sampled clients,	W000149	treatment of the client was taken to the ER on 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was given on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to high reading, signs symptoms and response to low readings, notifying the community services nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering injections via flex pen, signs and symptoms	06/01/2013

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	(#2), the facility neglected to implement its written policy and procedures to prevent neglect of the client in regard to weight loss. Findings include: 1. During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home, staff #2 assisted client #1 to wake and shower for the day at 6:05 AM. At 6:30 AM, staff #2 went to the kitchen and retrieved a slice of whole wheat bread and took the bread to client #1 in his bedroom. At 6:52 AM, staff #3 prompted client #1 to come and get his morning medications. Prior to client #1 receiving his morning medications, staff #3 did a blood sugar test which was 194 (test done after client #1 received the slice of bread). Client #1 received oral medications only at this time. At 7:25 AM, staff #3 verbally prompted client #1 to leave the dining room table to come back to the medication room. Client #1 refused to leave the dining room table and was attempting to get food to eat. Staff #3 grabbed the milk and the client's toast to encourage client #1 to follow her back to the office area. Client #1 left the dining room table and followed staff #3 to the office area. At 7:43 AM, staff #3 administered Novolog 70/30 15 units of insulin (Diabetes) via an insulin injection		of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.In order to prevent reoccurrence all staff will be trained on the risk plan, this training will include demonstration of reading blood sugars, administering injections via flex pen and use of the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again on 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A search for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addition, the use of electronic MARS will be investigated with upcoming new software.Until such time that	

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	pen to client #1. Client #1 then returned to the dining room table to eat his breakfast. At 7:45 AM, client #1 was served one slice of whole wheat toast, a bowl of grits, 1 small cup of apple juice, a cup of milk and a can of Glucerna (help minimize blood sugar spikes) shake to consume. Once client #1 ate the bowl of grits, staff #2, who was at the table standing near client #1, asked client #1 if he wanted more grits. Staff #2 placed a second serving of grits into client #1's bowl. At 8:47 AM, staff #2 asked client #1 if he wanted more grits. Staff #2 then placed a third serving of grits into client #1's bowl. Client #1 ate the bowl of grits and then drank his Glucerna shake. At 8:00 AM, in the group home's kitchen, a 5/8/13 Menu for a regular diet was posted next to the refrigerator. The group home did not have an 1800 calorie diabetic diet menu posted. The 5/8/13 menu indicated clients were to receive apple juice, 1 bowl of grits and a slice of toast. Interview with staff #2 on 5/8/13 at 6:30 AM indicated she was getting the slice of bread for client #1. When asked why, staff #2 stated she was getting the slice of bread "So [client #1's] blood sugar will not be low." Staff #2 indicated client #1's blood sugar would be high and then low. Interview with staff #2 on 5/8/13 at 8:04		the staff have shown competency in the skills, the nurse will continue to do observations at the home daily. Once competency has been demonstrated, the frequency of visits will decrease to every other day for two weeks then weekly for one month and monthly thereafter.Nursing staff trained staff on existing diabetic diets on 5/9/13 (these plans were not at the home at the time of the survey). As orders have changed and risk plans revised. Additional trainings will be provided. The dietician to make a home visit and develop sample 1800 calorie diabetic menus as guidelines for menu development by 5/22/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home within 2 weeks and will observe a meal and document her observations. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the	

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	AM stated client #1 was on a "diabetic diet." When asked where the diet was posted, staff #2 could not locate the diabetic diet. Staff #2 then went to the staff's office and stated client #1 was on an "1800 calorie diabetic diet." Staff #2 had an April 2013 Menu which had an 1800 calorie Diabetic diet written in red ink at the top of the menu. Staff #2 indicated client #1 could have what was written on the regular menu unless something was written in red by the menu item. The facility's posted May 2013 regular menu did not have any red notations on the 5/13 menus for the month of May. When asked what menu staff #2 followed for client #1 at the breakfast meal, staff #2 indicated she followed the posted menu in the kitchen. Interview with staff #3 on 5/8/13 at 8:15 AM indicated client #1 was diabetic and was on an 1800 calorie diabetic diet. Staff #2 indicated the posted menu in the kitchen was for a regular diet. When asked what client #1 was to receive since he was on an 1800 calorie diabetic diet, staff #3 stated "We just know what he should have." Staff #3 indicated staff did not assist client #1 to measure his food/servings. Staff #3 stated "He does not have to measure it out. We do by sight." Staff #3 stated the group home was using "an exchange." Staff #3 stated		Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The community services nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. Finally, Client #1 continues to see his doctor and specialist. His risk plan will be modified following each visit as necessary and will be distributed to the home and day program with additional training as needed.A risk plan for client #2 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. All staff will be trained on this plan by 6/5/13. Client will	

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	"One slice of bread equals 1 cup." Staff #3 indicated client #1 should not have received 3 bowls of grits at the breakfast meal. When asked if staff #3 had been trained in regard to signs and symptoms of low and/or high blood sugar, staff #3 stated she knew "some signs." Staff #3 indicated client #1 had not demonstrated any signs of low and/or high blood sugars when she worked. Staff #3 did not specifically indicate she had been trained and/or indicate when she was trained. During the 5/8/13 observation between 11:11 AM and 12:28 PM at day service program, At 11:11 AM, Client #1 was observed sitting at a table for lunch. Client #1 had sausage pizza broken up into pieces, salad with Italian dressing and a cup of water. Staff #6 indicated Client #1 had already eaten his french fries around 11:00 AM. Client #1 was observed to return to his day service room. At 11:15 AM, Staff #7 was observed to take Client #1's lunch plate from the microwave and offer it to him. Client #1 refused to eat anymore of his lunch. Client #1 kept his cup of water with him and continued to drink the water. At 11:22 AM, Client #1 was observed to refill his glass of water at the sink independently and then sit on the couch. At 11:50 AM, Client #1 was checking door knobs to straighten them		be evaluated by his primary physician and dietician by 6/15/13. Any recommendations will be added to his risk plan. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house. Daily visits will continue until staff has demonstrated competency and nurse monitoring will phase out according to competency demonstrated then monthly thereafter.	

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	and picking lint off carpet and eating it. At 11:56 AM, Client #1 was observed sitting on the couch holding his cup of water and drinking his water throughout the observation. At 12:02 PM, the client's diet roster was observed taped to a cabinet. The diet roster indicated Client #1 was on a "NCS" (No Concentrated Sweets) diet. At 12:24 PM, Client #1 was offered another lunch plate which he refused to eat. On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services (BDDS) reports and internal incident reports were reviewed and indicated the following: -A BDDS report dated 2/13/13 indicated on 2/9/13 staff reported Client #1's disposition had changed and his blood sugar was checked. Staff reported Client #1 did not want to eat and did not seem as active as usual. The report indicated Client #1's blood sugar was above the recommended level and the nurse instructed staff to take Client #1 to the hospital "immediately." The report indicated Client #1 was admitted to the hospital for high blood sugar and "a stomach infection which may have caused his sugar to raise." The report indicated Client #1 was discharged from the hospital on 2/13/13.			

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	An internal incident report dated 2/9/13 indicated Client #1 had been reported sick the previous day on 2/8/13. The report indicated Client #1's "vitals were extremely abnormal, he was not eating or drinking." The report indicated Client #1 was taken to the hospital. On 5/9/13 at 2:39 PM, the nurse emergency call log dated 2/9/13 indicated Client #1's blood sugar was in the 300's with irregular vitals prior to being admitted to the emergency room. -An incident report summary sheet dated 3/14/13 indicated Client #1 was drinking milk when his body motion became "unusual." The report indicated Client #1 began "twisting" and was about to fall out of chair. The report indicated staff called 911 and then the nurse. The report indicated Client #1 refused to go with the paramedics to the hospital and they waited for Client #1 to eat before they left. On 5/9/13 at 2:39 PM, review of the nurse emergency call log dated 3/14/13 indicated Client #1's blood sugar was 52 before the paramedics had arrived. -A BDDS report dated 4/19/13 indicated Client #1's blood sugar dropped to 30 at 3:45 PM. The report indicated staff attempted to give Client #1 soda but he got on the floor, curled up, and would not			

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	15G245	A. BUILDING 00 B. WING	05/20/2013

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	eat or drink. The report indicated Client #1 was transported to the hospital. On 5/9/13 at 2:39 PM, review of the nurse emergency call log indicated Client #1 was discharged from hospital after a blood sugar level of 32 and a diagnosis of urinary tract infection. -A BDDS report dated 4/25/13 indicated on 4/24/13 at 7:30 PM, Client #1 was out in the community shopping when he "appeared weak" and staff supported him to the ground. The report indicated an ambulance was driving by and was asked to assist. The paramedics checked Client #1's blood sugar which read 174. The report indicated staff began to take Client #1 home in the van when he began shaking. The report indicated the paramedics were located and took Client #1 to the hospital where he was checked and released the same day. During interview on 5/9/13 at 5:35 PM, the Behavioral Specialist indicated Client #1 was in an ambulance on his way to the hospital due to low blood sugar levels. On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension.			

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	The record review indicated a Diabetic Risk Plan for Client #1 dated 2/2013. The plan indicated Client #1 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." The plan indicated the intervention of "staff will record his blood sugar daily. Notify nurse of high or low glucose meter reading <100>250 [less than 100 or greater than 250]." The plan also indicated the following: "If blood sugar is below 80 or above 300, staff will call Nurse immediately. The nurse will report the reading to the doctor or nurse and then follow the instructions given to them." The Diabetic Plan for Client #1 also included additional instructions which indicated day program staff would monitor any signs of hypo or hyperglycemia and indicated signs would be posted at each center. The plan indicated a nurse would review the MAR (Medication Administration Record) each month and the service coordinator would review daily logs. The Diabetic Risk Plan neglected to include signs and/or symptoms of hypo/hyperglycemia. The Diabetic Risk Plan neglected to define a specific parameter in regards to nurse notification with Client #1's blood sugar level due to conflicting instruction on the			

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	risk plan. The Diabetic Risk plan neglected to tell staff what they were to do if Client #1's blood sugar was low and/or high. Client #1's Diabetic Risk Plan also neglected to indicate and/or include when client #1 was to have a snack. Client #1's 2/2013 to 5/2/2013 MARs indicated client #1's blood glucose levels were monitored in the AM (morning), Lunch, PM, Bedtime and as needed. The MARs indicated Client #1 was prescribed Novolog 70-30 Flexpen to inject "15 units Sub-Q [subcutaneous injection] 2 times a day (AM and PM) (Workshop Also). Hold if B/S (blood sugar) below 70 and call nurse." The MAR indicated Client #1 had a physician order dated 9/14/10 for sliding scale insulin at lunch time and bedtime. The MAR indicated the following sliding scale was to be administered: -2 units of Novolog if blood sugar (b/s) was between 100-200 -4 units of Novolog if b/s was between 201-250 -6 units of Novolog if b/s was between 251-300 -10 units of Novolog if b/s between 301-400 -12 units of Novolog if b/s was over 400. The MARs also indicated Client #1 had a			

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	physician order dated 9/16/10 for one can of Glucerna (used to minimize blood sugar spikes) given three times daily. Review of the MAR dated 4/01/13 to 4/30/13 and the MAR for 5/1/13 to 5/9/13 indicated staff neglected to document the administration of the sliding scale Novolog for Client #1 on the MAR as the 4/13 and 5/13 MARs were blank. The documentation for the administration of Client #1's sliding scale Novolog for 4/2013, and 5/1/13 to 5/9/13 was located on the "Sites for Subcutaneous Injection form," not the MAR. Interview with the Director of Health Care (DHCS) on 5/9/13 at 2:23 PM indicated she did not know where the documentation for the sliding scale Novolog was located, and staff should have been documenting administration of the sliding scale Novolog on the MAR sheets for Client #1. Review of the MARs for Client #1 from 2/1/2013 to 3/31/2013 indicated the facility neglected to document the units of Novolog administered for the sliding scale on Client #1's MAR. The MARS indicated only staff initials for administering the insulin and/or documented "H" for held. The number of			

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	administered units of the sliding scale Novolog was documented on the "Sites for Subcutaneous Injection," but the facility neglected to document the amount of units administered on 2/27/13, 3/1/13, 3/26/13, 3/31/13, 4/23/13, and 5/8/13 on any document. Client #1's blood sugar levels recorded on the 2/13 to 5/13 MARs indicated the facility staff administered the wrong number of units of the Novolog sliding scale, per physician orders, for Client #1 on the following dates: 3/10/13 (lunch) staff administered 6 units instead of 4 units for a b/s of 248 4/16/13 (bedtime) staff administered 4 units instead of 6 units for a b/s of 281 4/24/13 (bedtime) staff administered 6 units instead of 4 units for a b/s of 247 4/27/13 (lunch) 6 units were administered instead of 10 for a b/s of 303 5/6/13 (bedtime) staff administered 6 units instead of 4 units for a b/s of 243. On 5/10/13 at 12:58 PM, daily logs for Client #1 from 3/31/13 to 5/9/13 were reviewed. Per Client #1's Diabetic Risk Plan, staff were to call the nurse			

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	immediately if Client #1 had a blood sugar (b/s) reading of either " <100>250" [less than 100 or greater than 250]" or "below 80 or above 300." The daily log review indicated the following blood sugar readings outside of the parameters of "below 80 or above 300" without documentation of nurse notification by telephone: 2/3/13 b/s 60 (lunch) 2/13/13 bedtime (HS) 354 2/17/13 330 (lunch) 3/1/13 at lunch b/s 306 3/18/13 b/s 309 (HS) 3/20/13 b/s 322 (lunch) and 327 (HS) 3/24/13 b/s 322 (HS) 3/27/13 bedtime (HS) b/s 305 3/29/13 at lunch b/s of 303 4/5/13 b/s 385 (HS) 4/7/13 b/s 305 (HS) 4/9/13 b/s 311 (lunch) and 381 (HS)			

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	4/21/13 b/s 80 (lunch) and 50 (HS) 4/27/13 b/s 303 (lunch) 4/29/13 b/s 360 (HS). On 5/10/13 at 2:00 PM, the MARs for Client #1's day service program from 2/1/13 to 5/10/13 were reviewed. Client #1's MARs indicated the following before lunch blood sugar levels which were outside the parameter of less than 80 or greater than 300: 2/8/13 b/s 388 2/21/13 b/s 378 2/22/13 b/s 335 3/5/13 b/s 315 3/11/13 b/s 310 3/12/13 b/s 303 3/14/13 b/s 53 3/15/13 b/s 44 3/18/13 b/s 301 3/22/13 b/s 50 4/8/13 b/s 311			

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	4/10/13 b/s 409 4/12/13 b/s 319 4/18/13 b/s 302 4/19/13 b/s 311 5/9/13 325 5/10/13 b/s 348. The nurse emergency log from 2/1/13 to 5/9/13 indicated the nurse had received calls after hours regarding Client #1's blood sugar levels on 3/14/13, 4/19/13, and 2/8/13. There was no documentation of any calls from day services regarding Client #1's blood sugar levels. Review of the Medication Change Form from 2/13 to 5/13 indicated Client #1 had his physician ordered diet changed on 2/13/13 upon discharge from the hospital from a "No Concentrated Sweets Diet" to an "1800 ADA easy to chew diet." Client #1's Annual Nutrition Assessment dated 10/22/12 indicated Client #1's diet consisted of no concentrated sweets with the Glucerna shakes three times daily. Client #1's updated Annual Nutritional Assessment dated 4/2013 indicated Client #1's diet was changed to a diabetic 1800			

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	calorie diet with the Glucerna shakes three times daily. Review of nurses notes from 2/1/13 to 5/9/13 in the "Cumulative Medical Record" for Client #1 indicated the Nurse Supervisor was notified on 2/9/13 regarding Client #1's blood sugar level. The Cumulative Medical Record indicated the facility neglected to notify the facility's nurse of any additional low and/or high blood glucose readings as specified by the client's 2/13 risk plan. Client #1's Cumulative Medical records (nurses notes) indicated the facility's nursing services neglected to monitor client #1's high blood sugar levels as there was no documentation in regard to the client's blood sugar levels. The Cumulative Record also indicated the facility neglected to contact the client's doctor in regard to the client's low and/or high blood sugar levels. Client #1's Cumulative Medical Record indicated the following medical refusals by Client #1: On 5/4/12, the record indicated Client #1 was only able to complete a limited echocardiogram after he had refused an echocardiogram on 4/12/12. On 7/3/12, the cumulative medical record indicated Client #1 would not allow any part of his eye exam other than			

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	retinoscopy. The record indicated Client #1 must either be sedated or have drops installed on eyes 3 minutes prior to exam. The optometrist indicated, "It is of dire importance to have a dilated fundus exam as it has NEVER [sic] been accomplished!!!" On 8/3/12, the cumulative medical record indicated Client #1 refused to have eye drops administered into his eyes and the doctor's staff were unable to complete his eye assessment. The record indicated the dilated eye exam occurred on 8/31/12. On 1/16/2013, the cumulative medical record indicated Client #1 "was uncooperative" while getting lab work and the technician was unable to draw his blood. On 1/15/13, the cumulative medical record indicated Client #1 "was uncooperative" and was unable to complete his podiatry appointment. On 3/19/13, the cumulative medical record indicated Client #1 would not allow the technician to place electrodes or do a scan for an echocardiogram. On 3/19/13, Client #1 refused his blood work.			

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	Client #1's Individual Support Plan (ISP) dated 2/28/13 indicated the facility and/or the client's interdisciplinary team neglected to address the client's refusals for doctor appointments, labs, and tests. Client #1's Individual Support Plan (ISP) and cumulative medical record indicated the facility and/or the client's interdisciplinary team neglected to meet after each hospital visit to review additional health needs. Review of training documents on 5/9/13 at 11:40 AM indicated residential staff were trained on Client #1's ISP (Individual Support Plan) on 3/01/13 for 15 minutes which included Client #1's Diabetic Risk Plan. The facility neglected to train staff on signs and symptoms of hypo/hyperglycemia other than information contained within the risk plan. An interview on 5/8/13 at 12:15 PM with Staff #6 indicated Client #1 used to bring his lunch from home but he wouldn't eat it. Staff #6 indicated the day service staff tracked how much Client #1 ate throughout the day. Staff #6 indicated Client #1 usually ate his lunch unless his blood sugar was high during which case they offered Client #1 his lunch later. Staff #6 indicated Client #1 was also provided with a snack at 2:30 PM and			

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	4:00 PM from the group home. Staff #6 indicated the Health and Safety Technician checked Client #1's blood sugar right before lunch and then Client #1 was offered the general menu lunch with water. Staff #6 indicated the day service staff did not directly communicate with group home staff regarding Client #1's daily food intake or concerns. On 5/9/13 at 12:33 PM, the Service Coordinator (SC) and the Director of Health Care Services (DHCS) were interviewed. The SC indicated it would be the dietician's responsibility to give the facility guidance on Client #1's 1800 calorie diabetic diet. The SC indicated she did not know why there wasn't a specific menu plan for Client #1. The DHCS indicated the staff might have been trained on how to "exchange" items on the menu but wasn't sure if training forms were completed. An undated, non-client specific "Carbohydrate Serving List" was reviewed but the SC and the DHCS were not able to explain what the list indicated or how staff should use this list to offer diabetic appropriate meals. An "1800 ADA [American Diabetic Association] calorie diet" form was reviewed on 5/9/13 at 12:56 PM which included a list of "No. [number] of exchanges." The SC and the DHCS indicated they had not seen that form before. The DHCS indicated she			

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	would require training from the dietician in order to understand the form. The SC indicated she did not know why staff gave Client #1 a piece of bread at 6:30 AM on 5/8/13 prior to checking his blood sugar and before breakfast. The SC indicated there was no schedule of snacks for Client #1 as far as she was aware. The SC indicated she had trained staff on Client #1's annual ISP (Individual Service Plan) which included his diabetic plan on 3/1/13 but indicated the training did not include specific training on his 1800 ADA calorie diet, menu substitutions, or snacks. On 5/9/13 at 4:57 PM, interview with LPN #1 indicated if Client #1's blood sugar was outside the range given in the Diabetic Risk Plan, the staff should be rechecking the blood sugar. LPN #1 indicated the protocol for rechecking the blood sugar is not in the risk plan for Client #1. LPN #1 indicated the protocol for rechecking blood sugar should be in the risk plan for Client #1. LPN #1 indicated there was a discrepancy in the range of acceptable blood sugar levels for Client #1 as his Diabetic Risk Plan instructed staff to call the nurse for a blood sugar range of "<100>250 [less than 100 or greater than 250]' and/or "below 80 or above 300." LPN #1 did not indicate which range was correct for			

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	Client #1. LPN #1 indicated staff have been documenting blood sugar levels on the daily log and she receives those at least once weekly. LPN #1 didn't provide any further documentation staff called a nurse as Client #1's diabetic risk plan indicated. LPN #1 indicated she reviewed day service food intake, blood sugar levels, and MAR (medication administration record) on a monthly basis. LPN #1 indicated the staff at Client #1's group home had not been specifically trained on identifying signs and symptoms of high and low blood sugar. LPN #1 indicated she reviewed the client's MARs when she visited the group homes, or at the end of the month when they were faxed into the office. LPN #1 indicated she had started to track low blood sugars but did not track high blood sugar levels. LPN #1 indicated the staff received no client specific training for the signs and symptoms of high or low blood sugar. LPN #1 stated it was "inappropriate" for Client #1 to be offered three bowls of grits during breakfast on 5/8/13. LPN #1 indicated an adjustment was made for a diabetic diet on the April 2013 residential menu but no further menus had been developed. On 5/09/13 at 5:22 PM, the Behavioral Specialist indicated he wasn't sure if Client #1's IDT (interdisciplinary team) had met regarding the client's diabetes			

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	and hospitalizations. On 5/10/13 at 2:00 PM, Administrative Staff #4 (Developmental Specialist for day services) stated on 5/9/13, the Health and Safety Technician (HT #1) took Client #1's blood sugar level because staff noticed Client #1 was "not acting normal." HT #1 indicated she took Client #1's blood sugar and it read 36. Administrative Staff #4 indicated staff ran to get Client #1 a soda and called 911. Administrative Staff #4 indicated Client #1's blood sugar went up to about 54 after the soda. Administrative Staff #4 stated day services staff were trained on the high risk plans but were not trained on specifics on an "1800 calorie ADA diet." The Administrative Staff #4 was not sure whether "ADA" (American Diabetic Association) diet was specified in Client #1's risk plan. Administrative Staff #4 indicated Client #1 was also at the day service program during the 4/19/13 incident when Client #1 went to the hospital with a blood sugar of 30. Administrative Staff #4 indicated the day service staff were trained on the signs and symptoms of hyper and hypo-glycemia but indicated his staff were not trained on emergency protocol and what blood sugar level for Client #1 would warrant a call to 911. Administrative Staff #4 indicated Client #1's Diabetic Risk Plan does not			

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	indicate when to call 911. On 5/10/13 at 3:00 PM, HT #1 was interviewed and indicated Client #1 was in the dining room on 5/9/13 when he began to hit the table. Staff called HT #1 to check Client #1's blood sugar. HT #1 stated Client #1 "was combative" and she had difficulty obtaining his blood sugar which was 38. HT #1 indicated she tried to give Client #1 soda but he refused to drink it. HT #1 indicated Client #1 was getting into fetal position and was "fighting them" so they called 911. HT #1 indicated she was also present during the 4/19/13 incident. HT #1 indicated Client #1 went to the floor in a fetal position when they called 911. HT #1 indicated she was unsure of the physician ordered diet for Client #1 but indicated he does not get sweets and only water with lunch. HT #1 indicated staff were not trained on any protocol for when Client #1 refuses to eat lunch but she has been documenting his food intake and faxes it to the nurse bi-weekly. HT #1 indicated Client #1 will usually eat his lunch unless his blood sugar is high. HT #1 indicated Client #1 will usually eat his lunch later if his blood sugar is high. HT #1 indicated she would notify the nurse when Client #1's blood sugar was under 70 or over 200 by writing it down on the sliding scale form. HT #1 indicated she knew to call 911 when			

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	Client #1's blood sugar was low but did not know she might need to call 911 if Client #1's blood sugar was too high. On 5/10/13 at 11:11 AM, the Behavioral Specialist indicated Client #1 had been discharged from his emergency room visit on 5/9/13. No further documentation or reports from the 5/9/13 incident were available to review. The facility's policy and procedures were reviewed on 5/7/13 at 12:05 PM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...1. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients....." The policy defined neglect "...as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well being...." The policy indicated examples of neglect included, but were not limited to, ...depriving clients of medical care/treatment,...not providing and "adequate personal care...." 2. During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home, client #2 was tall and small in size. Client #2's shirt was big in size and hanging off the client's body. Client			

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#2 ate one bowl of grits, a slice of whole wheat toast, apple juice and 1 cup of milk. Staff #2 did not encourage and/or offer the client seconds of the breakfast meal.

Client #2's record was reviewed on 5/8/13 at 2:05 PM. Client #2's 2012 and 2013 Weight Chart indicated the following (not all inclusive):

-May 2012 209 pounds
-June 2012 219 pounds
-July 2012 188 pounds
-August 2012 183 pounds
-September 2012 183 pounds
-October 2012 176 pounds
-November 2012 177 pounds
-December 2012 169 pounds
-January 2013 167 pounds
-February 2013 178 pounds
-March 2013 176 pounds
-April 2013 159 pounds

Client #2's Weight Chart indicated client #2 was weighed once a month as there were no additional weights documented.

Client #2's Cumulative Medical Record indicated the following (not all inclusive):

-2/14/13 Client #2 saw his psychiatrist. The 2/14/13 consult indicated Inderal (behavior) medication was added to client #2's medication regime as the client had demonstrated increased aggression. The

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	2/14/13 consult indicated the psychiatrist reduced client #2's Klonopin as there was "no benefit from higher dose." -3/19/13 Client #2 saw his psychiatrist for continued treatment. The consult sheet indicated there was mild improvement in the client's behavior. -4/8/13 Client #2 saw his primary care doctor. The Cumulative Record indicated "...Wt (weight) loss etiology unclear...." The 4/8/13 record indicated client #1's weight was 160 pounds at the doctor's office. The record indicated client #2's doctor ordered labs of "CBC (blood count), Chem, TSH (thyroid test), Random Level, ACTH (hormone test), Lipids, U/A (urinalysis) & (and) Ca-19-9 (cancer antigen test)." -4/17/13 "Abnormal labs sent to [name of doctor]." -4/25/13 Hematology/Oncology record indicated "Pt (patient) evaluated for mild chronic leukopenia (decreased number of white blood cells) & thrombocytopenia (decreased number of platelets in the blood) w/ (with) progressive weight loss...." The 4/25/13 record indicated client #2's labs for cancer were "normal." The 4/25/13 note indicated client #2 weighed 161 pounds at the doctor's office.			

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	The record indicated "...Plan- advise primary MD (medical doctor) to consider imaging w/ CT (cat) scans if continued wt loss w/o (without) reason. -Follow-up in 3 mo (months) to reassess. -Possibly related to his medications. -0 (zero) sign of malignancy." Client #2's Cumulative Record indicated other than the 2 doctor visits, the facility's nursing staff neglected to document any concerns in regard to the significant weight loss between the months of March 2013 and April 2013 and January 2013 to February 2013. Client #2's 2/1/13 physician's order indicated client #2's diet was changed to a regular diet on 2/1/13. Client #2's 5/13 physician's order indicated client #2 had been on a "Portion Control" diet prior to 2/1/13 as the order for Portion Control had "D/C" (discontinue) written beside it. Client #2's 5/13 physician's order did not indicate how often staff were to weigh client #2. Client #2's 10/22/12 Annual Nutritional Assessment indicated client #2 weighed 176 pounds on 10/22/12. Client #2's ideal body weight was between 169 pounds and 186 pounds. The nutritional assessment indicated client #2 received a Portion Control diet. The assessment indicated			

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	client #2 was to continue a portion control diet and staff were to "Monitor Weight." The 10/22/12 assessment did not indicate how often staff were to weigh the client. Client #2's 10/22/12 Nutritional Assessment indicated the facility neglected to inform the facility's dietician of the client's significant weight loss. The assessment also indicated the facility failed to have the dietician re-assess client #2 in regard to the client's weight loss for recommendations to assist the client from further weight loss. Client #2's 2/13/13 Individual Support Plan (ISP) indicated the client's interdisciplinary team (IDT) neglected to meet, review and/or address client #2's weight loss. Client #2's 2/13/13 ISP also indicated the facility neglected to develop a risk plan for client #2's weight loss. Client #2's 2/13/13 ISP and/or Cumulative Medical Record indicated the facility neglected to obtain clarification on how often client #2 should be weighed to monitor the client's weight loss. Interview with staff #2 on 5/8/13 at 8:04 AM stated client #2 was on a "Portion Control diet." Staff #2 indicated client #2 was not to have seconds. Staff #2 indicated client #2 had been bigger in size in the past but had lost weight.			

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	Interview with Service Coordinator (SC) #1 on 5/10/13 at 11:55 PM when asked if client #2's IDT had met in regard to the client's weight loss, SC #1 stated "Yes and no. Team didn't but the guardian, [LPN #1] and I (SC#1) met by phone as concerned about his losing weight." SC #1 indicated client #2's guardian was concerned about the client losing weight. SC #1 indicated client #2 was placed on a regular diet in 2/13. SC #1 indicated she did not document the meeting about client #2's weight. When asked if staff had been trained in regard to client #2's diet, SC #1 stated "Yes. Should have been trained." SC #1 indicated she was not sure if the nurse had trained staff. Interview with the Director of Health Care Services (DHCS) on 5/10/13 at 1:40 PM indicated client #2 was going to the Oncologist at the request of the client's sister. The DHCS stated client #2's doctor indicated the client's weight loss was "due to psychotropic medication." Interview with administrative staff #1 and SC #1 on 5/10/13 at 1:45 PM indicated the dietician was at the group home in April 2013. SC #1 indicated she did not know if the dietician had re-assessed the client or not. Administrative staff #1 indicated client #2's weight was			

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	monitored once a month. Interview with LPN #1 on 5/10/13 at 1:57 PM indicated client #2 had seen his primary care doctor and oncologist for the client's weight loss. LPN #1 indicated client #2 had lost weight in the past month. LPN #1 indicated she had the client weighed at the day program on their scale. LPN #1 stated there had been a "20 pound weight difference." LPN #1 indicated she called the client's oncologist who told her to send the client to his primary care doctor first. LPN #1 indicated client #2's doctor saw the client and ordered labs to be done. LPN #1 stated the labs came back on 4/8/13 and they were "abnormal." LPN #1 indicated she faxed the labs to the oncologist and the primary care doctor. LPN #1 indicated the Oncologist saw the client on 4/25/13. LPN #1 stated "He (doctor) feels possibly related to medications." LPN #1 indicated she did not know which medication client #2's weight loss could be associated with. LPN #1 stated client #2 was "weighed once a month or however often I (LPN #1) request." LPN #1 indicated there was no documented assessment of the client's monthly weights. LPN #1 indicated the facility's dietician was not due to be at client #2's group home until 5/20/13.			

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	The facility's policy and procedures were reviewed on 5/7/13 at 12:05 PM. The facility's 2/15/12 policy entitled Policy For Handling Cases Of Neglect And Abuse indicated "...1. The Arc Northwest Indiana prohibits all abuse, neglect and exploitation of our clients....." The policy defined neglect "...as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well being...." The policy indicated examples of neglect included, but were not limited to, ...depriving clients of medical care/treatment,...not providing and "adequate personal care...." 9-3-2(a)			

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W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 2 of 2 allegations of client to client abuse reviewed, the facility failed to investigate the allegations of client to client abuse involving client #2 at the facility's owned day program. Findings include: The facility's reportable incident reports, internal Incident/Accident Reports (I/A) and/or investigations were reviewed on 5/7/13 at 11:53 AM. The facility's internal incident reports indicated the following: -3/18/13 "[Client #2] slapped [day program client] on part of face and neck." The facility's I/A indicated the day program client had "redness to his neck." -5/14/12 "[Client #2] threw an exercise ball at another client's (female peer) head for no apparent reason. The client was sitting at a table talking with staff. The client was sitting at a table talking with staff. [Client #2] reported to staff that [name of person] (hearing voices) told him that the client (female peer) was talking about him."	W000154	Treatment of clients: Team meetings will be held to evaluate the effectiveness of CI #2 behavior plan if necessary the plan will be revised. To ensure future compliance, posters explaining client rights and reporting requirements Including the need to report client to client aggression, were distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally all staff will be trained on reporting and investigation requirements for Abuse (including Client to client aggression), Neglect, and Exploitation at least annually unless changes occur or need requires this to be done more frequently. To ensure that Service Coordinators are trained on reporting and investigation requirements for Abuse Neglect (including client to client aggression), Exploitation and injuries of unknown origin the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and	06/01/2013

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	The facility's above mentioned I/A reports indicated the facility did not conduct an investigation in regard to the client to client incidents of aggression. Interview with administrative staff #1 on 5/10/13 at 1:50 PM indicated the facility did not investigate the 3/18/13 and/or 5/14/13 incidents of client to client aggression. 9-3-2(a)		DSPs will be trained on reporting and investigation requirements for Abuse Neglect (including the neglect of medical care), Exploitation and injuries of unknown origin prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral Health Director will review progress notes regularly.	

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W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 2 sampled clients (#2), the client's interdisciplinary team (IDT), failed to have the dietician re-assess a client in regard to the client's weight loss. Findings include: During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home, client #2 was tall and small in size. Client #2's shirt was big in size and hanging off the client's body. Client #2 ate one bowl of grits, a slice of whole wheat toast, apple juice and 1 cup of milk. Staff #2 did not encourage and/or offer the clients seconds of the breakfast meal. Client #2's record was reviewed on 5/8/13 at 2:05 PM. Client #2's 2012 and 2013 Weight Chart indicated the following (not all inclusive): -May 2012 209 pounds -June 2012 219 pounds -July 2012 188 pounds -August 2012 183 pounds	W000210	Client #2 saw his hematologist on 4/25/13 and will follow up on 7/25/13. He saw his primary physician on 4/8/13. He saw his Psychiatrist and will follow up again on 6/5/13. All of these appointments involved an evaluation of his weight loss. The dieitcian will evaluate Cl #2 by 6/15/13. With input from these past appointments a risk plan for client #2 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. Following each appointment his risk plan will be evaluated and revised. All staff will be trained on this plan by 6/5/13. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house. To ensure his weight continues to be monitored clients	06/01/2013

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	-September 2012 183 pounds -October 2012 176 pounds -November 2012 177 pounds -December 2012 169 pounds -January 2013 167 pounds -February 2013 178 pounds -March 2013 176 pounds -April 2013 159 pounds Client #2's Weight Chart indicated client #2 was weighed once a month as there were no additional weights documented. Client #2's 2/1/13 physician's order indicated client #2's diet was changed to a regular diet on 2/1/13. Client #2's 5/13 physician's order indicated client #2 had been on a "Portion Control" diet prior to 2/1/13 as the order for Portion Control had "D/C" (discontinue) written beside it. Client #2's 5/13 physician's order did not indicate how often staff were to weigh client #2. Client #2's 10/22/12 Annual Nutritional Assessment indicated client #2 weighed 176 pounds on 10/22/12. Client #2's ideal body weight was between 169 pounds and 186 pounds. The nutritional assessment indicated client #2 received a Portion Control diet. The assessment indicated client #2 was to continue a portion control diet and staff were to "Monitor Weight." The 10/22/12 assessment did not indicate how often staff were to weigh the client.		weight will be taken at the day program and sent to the nurse on a weekly basis, the Community Services Nurse will review these weekly weights at least monthly to ensure they continue to be taken. Also, the spread sheet in which all client weights are charted has been modified to include auto formatting to identify individuals whom have had a greater than 10% weigh change over a three month period. The community services clerk will distribute this weight chart to all service coordinators and nursing staff monthly so that any weight changes are addressed.	

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	Client #2's 10/22/12 Nutritional Assessment indicated the facility failed to inform the facility's dietician of the client's significant weight loss. The assessment also indicated the facility failed to have the dietician re-assess client #2 in regard to the client's weight loss for recommendations to assist the client from further weight loss. Interview with the Director of Health Care Services (DHCS) on 5/10/13 at 1:40 PM indicated client #2 was going to the Oncologist at the request of the client's sister. The DHCS stated client #2's doctor indicated the client's weight loss was "due to psychotropic medication." Interview with administrative staff #1 and SC #1 on 5/10/13 at 1:45 PM indicated the dietician was at the group home in April 2013. SC #1 indicated she did not know if the dietician had re-assessed the client or not. Administrative staff #1 indicated client #2's weight was monitored once a month. Interview with LPN #1 on 5/10/13 at 1:57 PM indicated client #2 had seen his primary care doctor and oncologist for the client's weight loss. LPN #1 indicated client #2 had lost weight in the past month. LPN #1 indicated she had the client weighed at the day program on their			

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	scale. LPN #1 stated there had been a "20 pound weight difference." LPN #1 indicated she called the client's oncologist who told her to send the client to his primary care doctor first. LPN #1 indicated client #2's doctor saw the client and ordered labs to be done. LPN #1 stated the labs came back on 4/8/13 and they were "abnormal." LPN #1 indicated she faxed the labs to the oncologist and the primary care doctor. LPN #1 indicated the Oncologist saw the client on 4/25/13. LPN #1 stated "He (doctor) feels possibly related to medications." LPN #1 indicated she did not know which medication client #2's weight loss could be associated with. LPN #1 stated client #2 was "weighed once a month or however often I (LPN #1) request." LPN #1 indicated there was no documented assessment of the client's monthly weights. LPN #1 indicated the facility's dietician was not due to be at client #2's group home until 5/20/13. 9-3-4(a)			

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W000227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview, the facility failed to include specific objectives in the Individual Service Plan to address the client's refusals of medical appointments and labs to prevent recurrence of potential hospitalizations/health risks associated with the client's diabetes for 1 of 3 sampled clients (Client #1). Findings include: On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Review of nurses notes from 2/1/13 to 5/9/13 in the "Cumulative Medical Record" for Client #1 indicated the following medical refusals by Client #1: On 5/4/12, the record indicated Client #1 was only able to complete a limited echocardiogram after he had refused an echocardiogram on 4/12/12.	W000227	A BSP will be developed to address refusals of labs and medical assessments by 5/28/13. Each of the other consumer's plans will also be evaluated for the need for additional interventions. All of the consumers will have their behavior plan evaluated by the team at least annually and HRC two times per year. They will be updated as new behaviors become evident and as needed. Service coordinators will evaluate the need for modifications to the plan following all incident reports and during weekly observations.	06/01/2013

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	On 7/3/12, the cumulative medical record indicated Client #1 would not allow any part of his eye exam other than retinoscopy. The record indicated Client #1 must either be sedated or have drops installed on eyes 3 minutes prior to exam. The optometrist indicated, "It is of dire importance to have a dilated fundus exam as it has NEVER [sic] been accomplished!!!" On 8/3/12, the cumulative medical record indicated Client #1 refused to have eye drops administered into his eyes and the doctor's staff were unable to complete his eye assessment. The record indicated the dilated eye exam occurred on 8/31/12. On 1/16/2013, the cumulative medical record indicated Client #1 "was uncooperative" while getting lab work and the technician was unable to draw his blood. On 1/15/13, the cumulative medical record indicated Client #1 "was uncooperative" and was unable to complete his podiatry appointment. On 3/19/13, the cumulative medical record indicated Client #1 would not allow the technician to place electrodes or do a scan for an echocardiogram.			

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	On 3/19/13, Client #1 refused his blood work. Client #1's Individual Support Plan (ISP) dated 2/28/13 indicated the facility and/or the client's interdisciplinary team failed to address the client's refusals for doctor appointments, labs, and tests. On 5/09/13 at 5:22 PM, the Behavioral Specialist indicated he wasn't sure if Client #1's IDT (interdisciplinary team) had met regarding the client's medical refusals. No further documentation was available at the time. 9-3-4(a)			

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W000318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 2 sampled clients (#1 and #2). The facility's Health Care Services failed to ensure its nursing services met the health care needs of the clients it served. The facility's Health Care Services failed to assess, monitor and/or address a client's health care needs in regard to diabetes, and failed to ensure facility staff were trained in regard to diabetes and following a diabetic diet. The facility's Health Care Services failed to ensure a client's doctor was contacted in regard to the client's low and/or high blood sugar levels. The facility's Health Care Services failed to ensure needed risk plans were developed for clients #1 and #2. The facility's Health Care Services failed to ensure medications for client #1's diabetes were administered as ordered. Findings include: 1. The facility's Health Care Services failed to ensure nursing services specifically addressed/developed a risk plan for client #1's diabetes. The facility's Health Care Services failed to ensure the nursing services obtained a diabetic menu	W000318	The client was taken to the ER on 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was given on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to high reading, signs symptoms and response to low readings, notifying the community services nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and	06/01/2013

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	for facility staff to follow/implement, and failed to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The facility's Health Care Services failed to ensure the nursing services monitored client #1's diabetes on a more frequent basis and notified the physician as indicated in the client's program plan. The facility's Health Care Services failed to ensure facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The facility's Health Care Services failed to ensure nursing services developed a risk plan for client #1's Urinary Tract Infection (UTI) and, failed to monitor and/or develop a risk plan for client #2's weight loss. Please see W331. 2. The facility's Health Care Services failed to ensure staff were trained in regard to diabetes and diabetic menu required to meet the health needs of Client #1. Please see W342. 3. The facility's Health Care Services failed to ensure medications were administered per the physician's orders for client #1. Please see W368. 9-3-6(a)		hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.In order to prevent reoccurrence all staff will be trained on the risk plan, this training will include demonstration of reading blood sugars, administering insulin injections via flex pen and use of the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again on 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A search for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addition, the use of electronic MARS will be investigated with upcoming new software.Until such time that	

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			the staff have shown competency in the skills, the nurse will continue to do observations at the home daily. Once competency has been demonstrated, the frequency of visits will decrease to every other day for two weeks then weekly for one month and monthly thereafter.Nursing staff trained staff on existing diabetic diets on 5/9/13 (these plans were not at the home at the time of the survey). As orders have changed and risk plans revised. Additional trainings will be provided. The dieitician to make a home visit and develop sample 1800 calorie diabetic menus as guidelines for menu development by 5/22/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home within 2 weeks and will observe a meal and document her observations. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the	

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			Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. Finally, Client #1 continues to see his doctor and specialist. His risk plan will be modified following each visit as necessary and will be distributed to the home and day program with additional training as needed.A risk plan for client #2 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. All staff will be trained on this plan by 6/5/13. Client will	

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			be evaluated by his primary physician and dietician by 6/15/13. Any recommendations will be added to his risk plan. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house. Daily visits will continue until staff have demonstrated competency and nurse monitoring will phase out according to competency demonstrated then monthly thereafter.	

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 2 of 2 sampled clients (#1 and #2), the facility nursing services failed to specifically address/develop a risk plan for client #1's diabetes. The facility nursing services failed to ensure a diabetic menu was developed for facility staff to follow/implement, and failed to ensure facility staff were adequately trained in regard to diabetes and the client's diabetic diet. The facility nursing services failed to monitor client #1's diabetes on a more frequent basis and notify the physician as indicated in the client's program. The facility nursing staff failed to ensure facility staff reported client #1's low and high blood sugar readings to nursing staff as outlined by the client's physician's order and/or program plan. The facility nursing staff failed to develop a risk plan for client #1's Urinary Tract Infection (UTI) and, failed to monitor and/or develop a risk plan for client #2's weight loss. Findings include: 1. During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home, staff #2 assisted client #1 to	W000331	The client was taken to the ER on 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was given on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to high reading, signs symptoms and response to low readings, notifying the community services nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and	06/01/2013

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	wake and shower for the day at 6:05 AM. At 6:30 AM, staff #2 went to the kitchen and retrieved a slice of whole wheat bread and took the bread to client #1 in his bedroom. At 6:52 AM, staff #3 prompted client #1 to come and get his morning medications. Prior to client #1 receiving his morning medications, staff #3 did a blood sugar test which was 194 (test done after client #1 received the slice of bread). Client #1 received oral medications only at this time. At 7:25 AM, staff #3 verbally prompted client #1 to leave the dining room table to come back to the medication room. Client #1 refused to leave the dining room table and was attempting to get food to eat. Staff #3 grabbed the milk and the client's toast to encourage client #1 to follow her back to the office area. Client #1 left the dining room table and followed staff #3 to the office area. At 7:43 AM, staff #3 administered Novolog 70/30 15 units of insulin (Diabetes) via an insulin injection pen to client #1. Client #1 then returned to the dining room table to eat his breakfast. At 7:45 AM, client #1 was served one slice of whole wheat toast, a bowl of grits, 1 small cup of apple juice, a cup of milk and a can of Glucerna (help minimize blood sugar spikes) shake to consume. Once client #1 ate the bowl of grits, staff #2, who was at the table standing near client #1, asked client #1 if		hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.In order to prevent reoccurrence all staff will be trained on the risk plan, this training will include demonstration of reading blood sugars, administering insulin injections via flex pen and use of the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again on 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A search for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addition, the use of electronic MARS will be investigated with upcoming new software.Until such time that	

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	he wanted more grits. Staff #2 placed a second serving of grits into client #1's bowl. At 8:47 AM, staff #2 asked client #1 if he wanted more grits. Staff #2 then placed a third serving of grits into client #1's bowl. Client #1 ate the bowl of grits and then drank his Glucerna shake. At 8:00 AM, in the group home's kitchen, a 5/8/13 Menu for a regular diet was posted next to the refrigerator. The group home did not have an 1800 calorie diabetic diet menu posted. The 5/8/13 menu indicated clients were to receive apple juice, 1 bowl of grits and a slice of toast. Interview with staff #2 on 5/8/13 at 6:30 AM indicated she was getting the slice of bread for client #1. When asked why, staff #2 stated she was getting the slice of bread "So [client #1's] blood sugar will not be low." Staff #2 indicated client #1's blood sugar would be high and then low. Interview with staff #2 on 5/8/13 at 8:04 AM stated client #1 was on a "diabetic diet." When asked where the diet was posted, staff #2 could not locate the diabetic diet. Staff #2 then went to the staff's office and stated client #1 was on an "1800 calorie diabetic diet." Staff #2 had an April 2013 Menu which had an 1800 calorie Diabetic diet written in red ink at the top of the menu. Staff #2 indicated client #1 could have what was		the staff have shown competency in the skills, the nurse will continue to do observations at the home daily. Once competency has been demonstrated, the frequency of visits will decrease to every other day for two weeks then weekly for one month and monthly thereafter.Nursing staff trained staff on existing diabetic diets on 5/9/13 (these plans were not at the home at the time of the survey). As orders have changed and risk plans revised. Additional trainings will be provided. The dietician to make a home visit and develop sample 1800 calorie diabetic menus as guidelines for menu development by 5/22/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home within 2 weeks and will observe a meal and document her observations. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the	

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	written on the regular menu unless something was written in red by the menu item. The facility's posted May 2013 regular menu did not have any red notations on the 5/13 menus for the month of May. When asked what menu staff #2 followed for client #1 at the breakfast meal, staff #2 indicated she followed the posted menu in the kitchen. Interview with staff #3 on 5/8/13 at 8:15 AM indicated client #1 was diabetic and was on an 1800 calorie diabetic diet. Staff #2 indicated the posted menu in the kitchen was for a regular diet. When asked what client #1 was to receive since he was on an 1800 calorie diabetic diet, staff #3 stated "We just know what he should have." Staff #3 indicated staff did not assist client #1 to measure his food/servings. Staff #3 stated "He does not have to measure it out. We do by sight." Staff #3 stated the group home was using "an exchange." Staff #3 stated "One slice of bread equals 1 cup." Staff #3 indicated client #1 should not have received 3 bowls of grits at the breakfast meal. When asked if staff #3 had been trained in regard to signs and symptoms of low and/or high blood sugar, staff #3 stated she knew "some signs." Staff #3 indicated client #1 had not demonstrated any signs of low and/or high blood sugars when she worked. Staff #3 did not		Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via a flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. Finally, Client #1 continues to see his doctor and specialist. His risk plan will be modified following each visit as necessary and will be distributed to the home and day program with additional training as needed.A risk plan for client #2 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. All staff will be trained on this plan by 6/5/13. Client will	

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	specifically indicate she had been trained and/or indicate when she was trained. During the 5/8/13 observation between 11:11 AM and 12:28 PM at day service program, At 11:11 AM, Client #1 was observed sitting at a table for lunch. Client #1 had sausage pizza broken up into pieces, salad with Italian dressing and a cup of water. Staff #6 indicated Client #1 had already eaten his french fries around 11:00 AM. Client #1 was observed to return to his day service room. At 11:15 AM, Staff #7 was observed to take Client #1's lunch plate from the microwave and offer it to him. Client #1 refused to eat anymore of his lunch. Client #1 kept his cup of water with him and continued to drink the water. At 11:22 AM, Client #1 was observed to refill his glass of water at the sink independently and then sit on the couch. At 11:50 AM, Client #1 was checking door knobs to straighten them and picking lint off carpet and eating it. At 11:56 AM, Client #1 was observed sitting on the couch holding his cup of water and drinking his water throughout the observation. At 12:02 PM, the client's diet roster was observed taped to a cabinet. The diet roster indicated Client #1 was on a "NCS" (No Concentrated Sweets) diet. At 12:24 PM, Client #1 was offered another lunch plate which he		be evaluated by his primary physician and dietician by 6/15/13. Any recommendations will be added to his risk plan. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house. Daily visits will continue until staff have demonstrated competency and nurse monitoring will phase out according to competency demonstrated then monthly thereafter.	

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	refused to eat. On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services (BDDS) reports and internal incident reports were reviewed and indicated the following: -A BDDS report dated 2/13/13 indicated on 2/9/13 staff reported Client #1's disposition had changed and his blood sugar was checked. Staff reported Client #1 did not want to eat and did not seem as active as usual. The report indicated Client #1's blood sugar was above the recommended level and the nurse instructed staff to take Client #1 to the hospital "immediately." The report indicated Client #1 was admitted to the hospital for high blood sugar and "a stomach infection which may have caused his sugar to raise." The report indicated Client #1 was discharged from the hospital on 2/13/13. An internal incident report dated 2/9/13 indicated Client #1 had been reported sick the previous day on 2/8/13. The report indicated Client #1's "vitals were extremely abnormal, he was not eating or drinking." The report indicated Client #1 was taken to the hospital. On 5/9/13 at 2:39 PM, the nurse emergency call log dated 2/9/13 indicated Client #1's blood			

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	sugar was in the 300's with irregular vitals prior to being admitted to the emergency room. -An incident report summary sheet dated 3/14/13 indicated Client #1 was drinking milk when his body motion became "unusual." The report indicated Client #1 began "twisting" and was about to fall out of chair. The report indicated staff called 911 and then the nurse. The report indicated Client #1 refused to go with the paramedics to the hospital and they waited for Client #1 to eat before they left. On 5/9/13 at 2:39 PM, review of the nurse emergency call log dated 3/14/13 indicated Client #1's blood sugar was 52 before the paramedics had arrived. -A BDDS report dated 4/19/13 indicated Client #1's blood sugar dropped to 30 at 3:45 PM. The report indicated staff attempted to give Client #1 soda but he got on the floor, curled up, and would not eat or drink. The report indicated Client #1 was transported to the hospital. On 5/9/13 at 2:39 PM, review of the nurse emergency call log indicated Client #1 was discharged from hospital after a blood sugar level of 32 and a diagnosis of urinary tract infection. -A BDDS report dated 4/25/13 indicated on 4/24/13 at 7:30 PM, Client #1 was out			

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	in the community shopping when he "appeared weak" and staff supported him to the ground. The report indicated an ambulance was driving by and was asked to assist. The paramedics checked Client #1's blood sugar which read 174. The report indicated staff began to take Client #1 home in the van when he began shaking. The report indicated the paramedics were located and took Client #1 to the hospital where he was checked and released the same day. During interview on 5/9/13 at 5:35 PM, the Behavioral Specialist indicated Client #1 was in an ambulance on his way to the hospital due to low blood sugar levels. On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. The record review indicated a Diabetic Risk Plan for Client #1 dated 2/2013. The plan indicated Client #1 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." The plan indicated the intervention of "staff will record his blood sugar daily. Notify nurse of high or low glucose meter			

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	reading <100>250 [less than 100 or greater than 250]." The plan also indicated the following: "If blood sugar is below 80 or above 300, staff will call Nurse immediately. The nurse will report the reading to the doctor or nurse and then follow the instructions given to them." The Diabetic Plan for Client #1 also included additional instructions which indicated day program staff would monitor any signs of hypo or hyperglycemia and indicated signs would be posted at each center. The plan indicated a nurse would review the MAR (Medication Administration Record) each month and the service coordinator would review daily logs. Nursing services failed to ensure Client #1's Diabetic Risk Plan included signs and/or symptoms of hypo/hyperglycemia. The facility's nursing services failed to ensure the client's Diabetic Risk Plan defined a specific parameter in regards to nurse notification with Client #1's blood sugar level due to conflicting instruction on the risk plan. Nursing services failed to ensure the Diabetic Risk plan instructed staff on what they were to do if Client #1's blood sugar was low and/or high. Nursing services failed to ensure Client #1's Diabetic Risk Plan also indicated and/or include when client #1 was to have a snack.			

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	Client #1's 2/2013 to 5/2/2013 MARs indicated client #1's blood glucose levels were monitored in the AM (morning), Lunch, PM, Bedtime and as needed. The MARs indicated Client #1 was prescribed Novolog 70-30 Flexpen to inject "15 units Sub-Q [subcutaneous injection] 2 times a day (AM and PM) (Workshop Also). Hold if B/S (blood sugar) below 70 and call nurse." The MAR indicated Client #1 had a physician order dated 9/14/10 for sliding scale insulin at lunch time and bedtime. The MAR indicated the following sliding scale was to be administered: -2 units of Novolog if blood sugar (b/s) was between 100-200 -4 units of Novolog if b/s was between 201-250 -6 units of Novolog if b/s was between 251-300 -10 units of Novolog if b/s between 301-400 -12 units of Novolog if b/s was over 400. The MARs also indicated Client #1 had a physician order dated 9/16/10 for one can of Glucerna (used to minimize blood sugar spikes) given three times daily. Review of the MAR dated 4/01/13 to 4/30/13 and the MAR for 5/1/13 to 5/9/13 indicated staff neglected to document the administration of the sliding scale			

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	Novolog for Client #1 on the MAR as the 4/13 and 5/13 MARs were blank. The documentation for the administration of Client #1's sliding scale Novolog for 4/2013, and 5/1/13 to 5/9/13 was located on the "Sites for Subcutaneous Injection form," not the MAR. Interview with the Director of Health Care (DHCS) on 5/9/13 at 2:23 PM indicated she did not know where the documentation for the sliding scale Novolog was located, and staff should have been documenting administration of the sliding scale Novolog on the MAR sheets for Client #1. Review of the MARs for Client #1 from 2/1/2013 to 3/31/2013 indicated the facility neglected to document the units of Novolog administered for the sliding scale on Client #1's MAR. The MARS indicated only staff initials for administering the insulin and/or documented "H" for held. The number of administered units of the sliding scale Novolog was documented on the "Sites for Subcutaneous Injection," but the facility neglected to document the amount of units administered on 2/27/13, 3/1/13, 3/26/13, 3/31/13, 4/23/13, and 5/8/13 on any document.			

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	Client #1's blood sugar levels recorded on the 2/13 to 5/13 MARs indicated the facility staff administered the wrong number of units of the Novolog sliding scale, per physician orders, for Client #1 on the following dates: 3/10/13 (lunch) staff administered 6 units instead of 4 units for a b/s of 248 4/16/13 (bedtime) staff administered 4 units instead of 6 units for a b/s of 281 4/24/13 (bedtime) staff administered 6 units instead of 4 units for a b/s of 247 4/27/13 (lunch) 6 units were administered instead of 10 for a b/s of 303 5/6/13 (bedtime) staff administered 6 units instead of 4 units for a b/s of 243. On 5/10/13 at 12:58 PM, daily logs for Client #1 from 3/31/13 to 5/9/13 were reviewed. Per Client #1's Diabetic Risk Plan, staff were to call the nurse immediately if Client #1 had a blood sugar (b/s) reading of either " <100>250" [less than 100 or greater than 250]" or "below 80 or above 300." The daily log review indicated the following blood sugar readings outside of the parameters of "below 80 or above 300" without documentation of nurse notification by			

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	telephone: 2/3/13 b/s 60 (lunch) 2/13/13 bedtime (HS) 354 2/17/13 330 (lunch) 3/1/13 at lunch b/s 306 3/18/13 b/s 309 (HS) 3/20/13 b/s 322 (lunch) and 327 (HS) 3/24/13 b/s 322 (HS) 3/27/13 bedtime (HS) b/s 305 3/29/13 at lunch b/s of 303 4/5/13 b/s 385 (HS) 4/7/13 b/s 305 (HS) 4/9/13 b/s 311 (lunch) and 381 (HS) 4/21/13 b/s 80 (lunch) and 50 (HS) 4/27/13 b/s 303 (lunch) 4/29/13 b/s 360 (HS). On 5/10/13 at 2:00 PM, the MARs for Client #1's day service program from			

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	2/1/13 to 5/10/13 were reviewed. Client #1's MARs indicated the following before lunch blood sugar levels which were outside the parameter of less than 80 or greater than 300: 2/8/13 b/s 388 2/21/13 b/s 378 2/22/13 b/s 335 3/5/13 b/s 315 3/11/13 b/s 310 3/12/13 b/s 303 3/14/13 b/s 53 3/15/13 b/s 44 3/18/13 b/s 301 3/22/13 b/s 50 4/8/13 b/s 311 4/10/13 b/s 409 4/12/13 b/s 319 4/18/13 b/s 302 4/19/13 b/s 311			

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	5/9/13 325 5/10/13 b/s 348. The nurse emergency log from 2/1/13 to 5/9/13 indicated the nurse had received calls after hours regarding Client #1's blood sugar levels on 3/14/13, 4/19/13, and 2/8/13. There was no documentation of any calls from day services regarding Client #1's blood sugar levels. Review of the Medication Change Form from 2/13 to 5/13 indicated Client #1 had his physician ordered diet changed on 2/13/13 upon discharge from the hospital from a "No Concentrated Sweets Diet" to an "1800 ADA easy to chew diet." Client #1's Annual Nutrition Assessment dated 10/22/12 indicated Client #1's diet consisted of no concentrated sweets with the Glucerna shakes three times daily. Client #1's updated Annual Nutritional Assessment dated 4/2013 indicated Client #1's diet was changed to a diabetic 1800 calorie diet with the Glucerna shakes three times daily. Review of nurses notes from 2/1/13 to 5/9/13 in the "Cumulative Medical Record" for Client #1 indicated the Nurse Supervisor was notified on 2/9/13 regarding Client #1's blood sugar level.			

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	The Cumulative Medical Record indicated the facility staff failed to notify the facility's nurse of any additional low and/or high blood glucose readings as specified by the client's 2/13 risk plan. Client #1's Cumulative Medical records (nurses notes) indicated the facility's nursing services failed to monitor client #1's high blood sugar levels as there was no documentation in regard to the client's blood sugar levels. The Cumulative Record also indicated the facility nursing services failed to contact the client's doctor in regard to the client's low and/or high blood sugar levels. Review of training documents on 5/9/13 at 11:40 AM indicated residential staff were trained on Client #1's ISP (Individual Support Plan) on 3/01/13 for 15 minutes which included Client #1's Diabetic Risk Plan. The facility nursing services failed to train staff on signs and symptoms of hypo/hyperglycemia other than information contained within the risk plan. An interview on 5/8/13 at 12:15 PM with Staff #6 indicated Client #1 used to bring his lunch from home but he wouldn't eat it. Staff #6 indicated the day service staff tracked how much Client #1 ate throughout the day. Staff #6 indicated Client #1 usually ate his lunch unless his			

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	blood sugar was high during which case they offered Client #1 his lunch later. Staff #6 indicated Client #1 was also provided with a snack at 2:30 PM and 4:00 PM from the group home. Staff #6 indicated the Health and Safety Technician checked Client #1's blood sugar right before lunch and then Client #1 was offered the general menu lunch with water. Staff #6 indicated the day service staff did not directly communicate with group home staff regarding Client #1's daily food intake or concerns. On 5/9/13 at 12:33 PM, the Service Coordinator (SC) and the Director of Health Care Services (DHCS) were interviewed. The SC indicated it would be the dietician's responsibility to give the facility guidance on Client #1's 1800 calorie diabetic diet. The SC indicated she did not know why there wasn't a specific menu plan for Client #1. The DHCS indicated the staff might have been trained on how to "exchange" items on the menu but wasn't sure if training forms were completed. An undated, non-client specific "Carbohydrate Serving List" was reviewed but the SC and the DHCS were not able to explain what the list indicated or how staff should use this list to offer diabetic appropriate meals. An "1800 ADA [American Diabetic Association] calorie diet" form was reviewed on 5/9/13			

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	at 12:56 PM which included a list of "No. [number] of exchanges." The SC and the DHCS indicated they had not seen that form before. The DHCS indicated she would require training from the dietician in order to understand the form. The SC indicated she did not know why staff gave Client #1 a piece of bread at 6:30 AM on 5/8/13 prior to checking his blood sugar and before breakfast. The SC indicated there was no schedule of snacks for Client #1 as far as she was aware. The SC indicated she had trained staff on Client #1's annual ISP (Individual Service Plan) which included his diabetic plan on 3/1/13 but indicated the training did not include specific training on his 1800 ADA calorie diet, menu substitutions, or snacks. On 5/9/13 at 4:57 PM, interview with LPN #1 indicated if Client #1's blood sugar was outside the range given in the Diabetic Risk Plan, the staff should be rechecking the blood sugar. LPN #1 indicated the protocol for rechecking the blood sugar is not in the risk plan for Client #1. LPN #1 indicated the protocol for rechecking blood sugar should be in the risk plan for Client #1. LPN #1 indicated there was a discrepancy in the range of acceptable blood sugar levels for Client #1 as his Diabetic Risk Plan			

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	instructed staff to call the nurse for a blood sugar range of "<100>250 [less than 100 or greater than 250]' and/or "below 80 or above 300." LPN #1 did not indicate which range was correct for Client #1. LPN #1 indicated staff have been documenting blood sugar levels on the daily log and she receives those at least once weekly. LPN #1 didn't provide any further documentation staff called a nurse as Client #1's diabetic risk plan indicated. LPN #1 indicated she reviewed day service food intake, blood sugar levels, and MAR (medication administration record) on a monthly basis. LPN #1 indicated the staff at Client #1's group home had not been specifically trained on identifying signs and symptoms of high and low blood sugar. LPN #1 indicated she reviewed the client's MARs when she visited the group homes, or at the end of the month when they were faxed into the office. LPN #1 indicated she had started to track low blood sugars but did not track high blood sugar levels. LPN #1 indicated the staff received no client specific training for the signs and symptoms of high or low blood sugar. LPN #1 stated it was "inappropriate" for Client #1 to be offered three bowls of grits during breakfast on 5/8/13. LPN #1 indicated an adjustment was made for a diabetic diet on the April 2013 residential menu but no further			

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	menus had been developed. On 5/10/13 at 2:00 PM, Administrative Staff #4 (Developmental Specialist for day services) stated on 5/9/13, the Health and Safety Technician (HT #1) took Client #1's blood sugar level because staff noticed Client #1 was "not acting normal." HT #1 indicated she took Client #1's blood sugar and it read 36. Administrative Staff #4 indicated staff ran to get Client #1 a soda and called 911. Administrative Staff #4 indicated Client #1's blood sugar went up to about 54 after the soda. Administrative Staff #4 stated day services staff were trained on the high risk plans but were not trained on specifics on an "1800 calorie ADA diet." The Administrative Staff #4 was not sure whether "ADA" (American Diabetic Association) diet was specified in Client #1's risk plan. Administrative Staff #4 indicated Client #1 was also at the day service program during the 4/19/13 incident when Client #1 went to the hospital with a blood sugar of 30. Administrative Staff #4 indicated the day service staff were trained on the signs and symptoms of hyper and hypo-glycemia but indicated his staff were not trained on emergency protocol and what blood sugar level for Client #1 would warrant a call to 911. Administrative Staff #4 indicated Client #1's Diabetic Risk Plan does not			

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	indicate when to call 911. On 5/10/13 at 3:00 PM, the day services Health and Safety Technician (HT #1) was interviewed and indicated Client #1 was in the day services dining room on 5/9/13 when he began to hit the table. Staff called HT #1 to check Client #1's blood sugar. HT #1 stated Client #1 "was combative" and she had difficulty obtaining his blood sugar which was 38. HT #1 indicated she tried to give Client #1 soda but he refused to drink it. HT #1 indicated Client #1 was getting into fetal position and was "fighting them" so they called 911. HT #1 indicated she was also present during the 4/19/13 incident. HT #1 indicated Client #1 went to the floor in a fetal position when they called 911. HT #1 indicated she was unsure of the physician ordered diet for Client #1 but indicated he does not get sweets and only water with lunch. HT #1 indicated staff were not trained on any protocol for when Client #1 refuses to eat lunch but she has been documenting his food intake and faxes it to the nurse bi-weekly. HT #1 indicated Client #1 will usually eat his lunch unless his blood sugar is high. HT #1 indicated Client #1 will usually eat his lunch later if his blood sugar is high. HT #1 indicated she would notify the nurse when Client #1's blood sugar was under 70 or over 200 by writing it down on the			

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	sliding scale form. HT #1 indicated she knew to call 911 when Client #1's blood sugar was low but did not know she might need to call 911 if Client #1's blood sugar was too high. On 5/10/13 at 11:11 AM, the Behavioral Specialist indicated Client #1 had been discharged from his emergency room visit on 5/9/13. No further documentation or reports from the 5/9/13 incident were available to review. 2. On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services (BDDS) reports and internal incident reports were reviewed and indicated the following: -A BDDS report dated 4/19/13 indicated Client #1's blood sugar dropped to 30 at 3:45 PM. The report indicated staff attempted to give Client #1 soda but he got on the floor, curled up, and would not eat or drink. The report indicated Client #1 was transported to the hospital. On 5/9/13 at 2:39 PM, review of the nurse emergency call log indicated Client #1 was discharged from hospital after a blood sugar level of 32 and a diagnosis of urinary tract infection. -A BDDS report dated 4/25/13 indicated on 4/24/13 at 7:30 PM, Client #1 was out			

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	in the community shopping when he "appeared weak" and staff supported him to the ground. The report indicated an ambulance was driving by and was asked to assist. The paramedics checked Client #1's blood sugar which read 174. The report indicated staff began to take Client #1 home in the van when he began shaking. The report indicated the paramedics were located and took Client #1 to the hospital where he was checked and released the same day. On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Client #1's Individual Support Plan (ISP) dated 2/28/13 indicated the facility's nursing services failed to develop and add a risk plan for Client #1's UTI diagnosis on 4/19/13. On 5/9/13 at 12:33 PM, the Service Coordinator (SC) was interviewed and indicated Client #1's fluids were increased for 2 weeks as recommended by the emergency room physician after Client #1's 4/24/13 hospital visit due to a diagnosis of Acute Hematuria (blood tinged urine). SC indicated no risk plan			

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	had been developed by the nurse for Client #1's UTI but Client #1 was recommended to have a follow up urinalysis. On 5/09/13 at 5:22 PM, the Behavioral Specialist indicated he wasn't sure if Client #1's IDT (interdisciplinary team) had met regarding the client's hospitalizations to assure Client #1's risk plans met his current needs. No further documentation was available at the time. 3. During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home, client #2 was tall and small in size. Client #2's shirt was big in size and hanging off the client's body. Client #2 ate one bowl of grits, a slice of whole wheat toast, apple juice and 1 cup of milk. Staff #2 did not encourage and/or offer the client seconds of the breakfast meal. Client #2's record was reviewed on 5/8/13 at 2:05 PM. Client #2's 2012 and 2013 Weight Chart indicated the following (not all inclusive): -May 2012 209 pounds -June 2012 219 pounds -July 2012 188 pounds -August 2012 183 pounds -September 2012 183 pounds -October 2012 176 pounds			

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	-November 2012 177 pounds -December 2012 169 pounds -January 2013 167 pounds -February 2013 178 pounds -March 2013 176 pounds -April 2013 159 pounds Client #2's Weight Chart indicated client #2 was weighed once a month as there were no additional weights documented. Client #2's Cumulative Medical Record indicated the following (not all inclusive): -2/14/13 Client #2 saw his psychiatrist. The 2/14/13 consult indicated Inderal (behavior) medication was added to client #2's medication regime as the client had demonstrated increased aggression. The 2/14/13 consult indicated the psychiatrist reduced client #2's Klonopin as there was "no benefit from higher dose." -3/19/13 Client #2 saw his psychiatrist for continued treatment. The consult sheet indicated there was mild improvement in the client's behavior. -4/8/13 Client #2 saw his primary care doctor. The Cumulative Record indicated "...Wt (weight) loss etiology unclear...." The 4/8/13 record indicated client #1's weight was 160 pounds at the doctor's office. The record indicated client #2's doctor ordered labs of "CBC (blood			

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	count), Chem, TSH (thyroid test), Random Level, ACTH (hormone test), Lipids, U/A (urinalysis) & (and) Ca-19-9 (cancer antigen test)." -4/17/13 "Abnormal labs sent to [name of doctor]." -4/25/13 Hematology/Oncology record indicated "Pt (patient) evaluated for mild chronic leukopenia (decreased number of white blood cells) & thrombocytopenia (decreased number of platelets in the blood) w/ (with) progressive weight loss...." The 4/25/13 record indicated client #2's labs for cancer were "normal." The 4/25/13 note indicated client #2 weighed 161 pounds at the doctor's office. The record indicated "...Plan- advise primary MD (medical doctor) to consider imaging w/ CT (cat) scans if continued wt loss w/o (without) reason. -Follow-up in 3 mo (months) to reassess. -Possibly related to his medications. -0 (zero) sign of malignancy." Client #2's Cumulative Record indicated other than the 2 doctor visits, the facility's nursing staff failed to document any concerns in regard to the significant weight loss between the months of March 2013 and April 2013 and January 2013 to February 2013.			

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	Client #2's 2/1/13 physician's order indicated client #2's diet was changed to a regular diet on 2/1/13. Client #2's 5/13 physician's order indicated client #2 had been on a "Portion Control" diet prior to 2/1/13 as the order for Portion Control had "D/C" (discontinue) written beside it. Client #2's 5/13 physician's order did not indicate how often staff were to weigh client #2. Client #2's 10/22/12 Annual Nutritional Assessment indicated client #2 weighed 176 pounds on 10/22/12. Client #2's ideal body weight was between 169 pounds and 186 pounds. The nutritional assessment indicated client #2 received a Portion Control diet. The assessment indicated client #2 was to continue a portion control diet and staff were to "Monitor Weight." The 10/22/12 assessment did not indicate how often staff were to weigh the client. Client #2's 10/22/12 Nutritional Assessment indicated the facility's nursing services failed to inform the facility's dietician of the client's significant weight loss to have the dietician re-assess client #2 in regard to the client's weight loss. Client #2's 2/13/13 Individual Support Plan (ISP) indicated the facility's nursing services failed to develop a risk plan for client #2's weight loss.			

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Client #2's 2/13/13 ISP and/or Cumulative Medical Record indicated the facility's nursing services failed to obtain clarification on how often client #2 should be weighed to monitor the client's weight loss.

Interview with staff #2 on 5/8/13 at 8:04 AM stated client #2 was on a "Portion Control diet." Staff #2 indicated client #2 was not to have seconds. Staff #2 indicated client #2 had been bigger in size in the past but had lost weight.

Interview with Service Coordinator (SC) #1 on 5/10/13 at 11:55 PM when asked if client #2's IDT had met in regard to the client's weight loss, SC #1 stated "Yes and no. Team didn't but the guardian, [LPN #1] and I (SC #1) met by phone as concerned about his losing weight." SC #1 indicated client #2's guardian was concerned about the client losing weight. SC #1 indicated client #2 was placed on a regular diet in 2/13. SC #1 indicated she did not document the meeting about client #2's weight. When asked if staff had been trained in regard to client #2's diet, SC #1 stated "Yes. Should have been trained." SC #1 indicated she was not sure if the nurse had trained staff.

Interview with the Director of Health

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	Care Services (DHCS) on 5/10/13 at 1:40 PM indicated client #2 was going to the Oncologist at the request of the client's sister. The DHCS stated client #2's doctor indicated the client's weight loss was "due to psychotropic medication." Interview with administrative staff #1 and SC #1 on 5/10/13 at 1:45 PM indicated the dietician was at the group home in April 2013. SC #1 indicated she did not know if the dietician had re-assessed the client or not. Administrative staff #1 indicated client #2's weight was monitored once a month. Interview with LPN #1 on 5/10/13 at 1:57 PM indicated client #2 had seen his primary care doctor and oncologist for the client's weight loss. LPN #1 indicated client #2 had lost weight in the past month. LPN #1 indicated she had the client weighed at the day program on their scale. LPN #1 stated there had been a "20 pound weight difference." LPN #1 indicated she called the client's oncologist who told her to send the client to his primary care doctor first. LPN #1 indicated client #2's doctor saw the client and ordered labs to be done. LPN #1 stated the labs came back on 4/8/13 and they were "abnormal." LPN #1 indicated she faxed the labs to the oncologist and the primary care doctor. LPN #1			

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	indicated the Oncologist saw the client on 4/25/13. LPN #1 stated "He (doctor) feels possibly related to medications." LPN #1 indicated she did not know which medication client #2's weight loss could be associated with. LPN #1 stated client #2 was "weighed once a month or however often I (LPN #1) request." LPN #1 indicated there was no documented assessment of the client's monthly weights. LPN #1 indicated the facility's dietician was not due to be at client #2's group home until 5/20/13. 9-3-6(a)			

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W000342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on observation, interview and record review, the facility's nursing services failed to ensure staff were trained in regard to diabetes and diabetic menu required to meet the health needs of 1 of 3 sampled clients (Client #1). Findings include: During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home, staff #2 assisted client #1 to wake and shower for the day at 6:05 AM. At 6:30 AM, staff #2 went to the kitchen and retrieved a slice of whole wheat bread and took the bread to client #1 in his bedroom. At 6:52 AM, staff #3 prompted client #1 to come and get his morning medications. Prior to client #1 receiving his morning medications, staff #3 did a blood sugar test which was 194 (test done after client #1 received the slice of bread). Client #1 received oral medications only at this time. At 7:25 AM, staff #3	W000342	The client was taken to the ER on 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was given on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to high reading, signs symptoms and response to low readings, notifying the community services nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun	06/01/2013

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	verbally prompted client #1 to leave the dining room table to come back to the medication room. Client #1 refused to leave the dining room table and was attempting to get food to eat. Staff #3 grabbed the milk and the client's toast to encourage client #1 to follow her back to the office area. Client #1 left the dining room table and followed staff #3 to the office area. At 7:43 AM, staff #3 administered Novolog 70/30 15 units of insulin (Diabetes) via an insulin injection pen to client #1. Client #1 then returned to the dining room table to eat his breakfast. At 7:45 AM, client #1 was served one slice of whole wheat toast, a bowl of grits, 1 small cup of apple juice, a cup of milk and a can of Glucerna (help minimize blood sugar spikes) shake to consume. Once client #1 ate the bowl of grits, staff #2, who was at the table standing near client #1, asked client #1 if he wanted more grits. Staff #2 placed a second serving of grits into client #1's bowl. At 8:47 AM, staff #2 asked client #1 if he wanted more grits. Staff #2 then placed a third serving of grits into client #1's bowl. Client #1 ate the bowl of grits and then drank his Glucerna shake. At 8:00 AM, in the group home's kitchen, a 5/8/13 Menu for a regular diet was posted next to the refrigerator. The group home did not have an 1800 calorie diabetic diet menu posted. The 5/8/13 menu indicated		training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.In order to prevent reoccurrence all staff will be trained on the risk plan, this training will include demonstration of reading blood sugars, administering insulin injections via flex pen and use of the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again on 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The community services nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A search	

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	clients were to receive apple juice, 1 bowl of grits and a slice of toast. Interview with staff #2 on 5/8/13 at 6:30 AM indicated she was getting the slice of bread for client #1. When asked why, staff #2 stated she was getting the slice of bread "So [client #1's] blood sugar will not be low." Staff #2 indicated client #1's blood sugar would be high and then low. Interview with staff #2 on 5/8/13 at 8:04 AM stated client #1 was on a "diabetic diet." When asked where the diet was posted, staff #2 could not locate the diabetic diet. Staff #2 then went to the staff's office and stated client #1 was on an "1800 calorie diabetic diet." Staff #2 had an April 2013 Menu which had 1800 calorie Diabetic diet written in red ink at the top of the menu. Staff #2 indicated client #1 could have what was written on the regular menu unless something was written in red by the menu item. The facility's posted May 2013 regular menu did not have any red notations on the 5/13 menus for the month of May. When asked what menu staff #2 followed for client #1 at the breakfast meal, staff #2 indicated she followed the posted menu in the kitchen. Interview with staff #3 on 5/8/13 at 8:15 AM indicated client #1 was diabetic and		for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addition, the use of electronic MARS will be investigated with upcoming new software.Until such time that the staff have shown competency in the skills, the nurse will continue to do observations at the home daily. Once competency has been demonstrated, the frequency of visits will decrease to every other day for two weeks then weekly for one month and monthly thereafter.Nursing staff trained staff on existing diabetic diets on 5/9/13 (these plans were not at the home at the time of the survey). As orders have changed and risk plans revised. Additional trainings will be provided. The dietician to make a home visit and develop sample 1800 calorie diabetic menus as guidelines for menu development by 5/22/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training thedietician will visit the home within 2 weeks and will observe a meal and document her observations. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations	

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	was on an 1800 calorie diabetic diet. Staff #2 indicated the posted menu in the kitchen was for a regular diet. When asked what client #1 was to receive since he was on an 1800 calorie diabetic diet, staff #3 stated "We just know what he should have." Staff #3 indicated staff did not assist client #1 to measure his food/servings. Staff #3 stated "He does not have to measure it out. We do by sight." Staff #3 stated the group home was using "an exchange." Staff #3 stated "One slice of bread equals 1 cup." Staff #3 indicated client #1 should not have received 3 bowls of grits at the breakfast meal. When asked if staff #3 had been trained in regard to signs and symptoms of low and/or high blood sugar, staff #3 stated she knew "some signs." Staff #3 indicated client #1 had not demonstrated any signs of low and/or high blood sugars when she worked. Staff #3 did not specifically indicate she had been trained and/or indicate when she was trained. During the 5/8/13 observation between 11:11 AM and 12:28 PM at day service program, At 11:11 AM, Client #1 was observed sitting at a table for lunch. Client #1 had sausage pizza broken up into pieces, salad with Italian dressing and a cup of water. Staff #6 indicated Client #1 had already eaten his french fries around 11:00 AM. Client #1 was		have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. Finally, Client #1 continues to see his doctor and specialist. His risk plan will be modified following each visit as necessary and will be distributed to the home and	

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	observed to return to his day service room. At 11:15 AM, Staff #7 was observed to take Client #1's lunch plate from the microwave and offer it to him. Client #1 refused to eat anymore of his lunch. Client #1 kept his cup of water with him and continued to drink the water. At 11:22 AM, Client #1 was observed to refill his glass of water at the sink independently and then sit on the couch. At 11:50 AM, Client #1 was checking door knobs to straighten them and picking lint off carpet and eating it. At 11:56 AM, Client #1 was observed sitting on the couch holding his cup of water and drinking his water throughout the observation. At 12:02 PM, the client's diet roster was observed taped to a cabinet. The diet roster indicated Client #1 was on a "NCS" (No Concentrated Sweets) diet. At 12:24 PM, Client #1 was offered another lunch plate which he refused to eat. On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services (BDDS) reports and internal incident reports were reviewed and indicated the following: -A BDDS report dated 2/13/13 indicated on 2/9/13 staff reported Client #1's disposition had changed and his blood sugar was checked. Staff reported Client		day program with additional training as needed.A risk plan for client #2 was developed on 5/28/13 to include weekly weights and guidelines for reporting changes. All staff will be trained on this plan by 6/5/13. Client will be evaluated by his primary physician and dietician by 6/15/13. Any recommendations will be added to his risk plan. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house. Daily visits will continue until staff have demonstrated competency and nurse monitoring will phase out according to competency demonstrated then monthly thereafter.	

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	#1 did not want to eat and did not seem as active as usual. The report indicated Client #1's blood sugar was above the recommended level and the nurse instructed staff to take Client #1 to the hospital "immediately." The report indicated Client #1 was admitted to the hospital for high blood sugar and "a stomach infection which may have caused his sugar to raise." The report indicated Client #1 was discharged from the hospital on 2/13/13. An internal incident report dated 2/9/13 indicated Client #1 had been reported sick the previous day on 2/8/13. The report indicated Client #1's "vitals were extremely abnormal, he was not eating or drinking." The report indicated Client #1 was taken to the hospital. On 5/9/13 at 2:39 PM, the nurse emergency call log dated 2/9/13 indicated Client #1's blood sugar was in the 300's with irregular vitals prior to being admitted to the emergency room. -An incident report summary sheet dated 3/14/13 indicated Client #1 was drinking milk when his body motion became "unusual." The report indicated Client #1 began "twisting" and was about to fall out of chair. The report indicated staff called 911 and then the nurse. The report indicated Client #1 refused to go with the			

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	paramedics to the hospital and they waited for Client #1 to eat before they left. On 5/9/13 at 2:39 PM, review of the nurse emergency call log dated 3/14/13 indicated Client #1's blood sugar was 52 before the paramedics had arrived. -A BDDS report dated 4/19/13 indicated Client #1's blood sugar dropped to 30 at 3:45 PM. The report indicated staff attempted to give Client #1 soda but he got on the floor, curled up, and would not eat or drink. The report indicated Client #1 was transported to the hospital. On 5/9/13 at 2:39 PM, review of the nurse emergency call log indicated Client #1 was discharged from hospital after a blood sugar level of 32 and a diagnosis of urinary tract infection. -A BDDS report dated 4/25/13 indicated on 4/24/13 at 7:30 PM, Client #1 was out in the community shopping when he "appeared weak" and staff supported him to the ground. The report indicated an ambulance was driving by and was asked to assist. The paramedics checked Client #1's blood sugar which read 174. The report indicated staff began to take Client #1 home in the van when he began shaking. The report indicated the paramedics were located and took Client #1 to the hospital where he was checked and released the same day.			

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	During interview on 5/9/13 at 5:35 PM, the Behavioral Specialist indicated Client #1 was in an ambulance on his way to the hospital due to low blood sugar levels. On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. The record review indicated a Diabetic Risk Plan for Client #1 dated 2/2013. The plan indicated Client #1 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." The plan indicated the intervention of "staff will record his blood sugar daily. Notify nurse of high or low glucose meter reading <100>250 [less than 100 or greater than 250]." The plan also indicated the following: "If blood sugar is below 80 or above 300, staff will call Nurse immediately. The nurse will report the reading to the doctor or nurse and then follow the instructions given to them." The Diabetic Plan for Client #1 also included additional instructions which indicated day program staff would monitor any signs of hypo or hyperglycemia and indicated signs would			

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	be posted at each center. The plan indicated a nurse would review the MAR (Medication Administration Record) each month and the service coordinator would review daily logs. The Diabetic Risk Plan neglected to include signs and/or symptoms of hypo/hyperglycemia. The Diabetic Risk Plan neglected to define a specific parameter in regards to nurse notification with Client #1's blood sugar level due to conflicting instruction on the risk plan. The Diabetic Risk plan failed to instruct staff what they were to do if Client #1's blood sugar was low and/or high. Client #1's Diabetic Risk Plan also failed to indicate and/or include when client #1 was to have a snack. Review of the Medication Change Form from 2/13 to 5/13 indicated Client #1 had his physician ordered diet changed on 2/13/13 upon discharge from the hospital from a "No Concentrated Sweets Diet" to an "1800 ADA easy to chew diet." Client #1's Annual Nutrition Assessment dated 10/22/12 indicated Client #1's diet consisted of no concentrated sweets with the Glucerna shakes three times daily. Client #1's updated Annual Nutritional Assessment dated 4/2013 indicated Client #1's diet was changed to a diabetic 1800 calorie diet with the Glucerna shakes three times daily.			

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	Review of training documents on 5/9/13 at 11:40 AM indicated residential staff were trained on Client #1's ISP (Individual Support Plan) on 3/01/13 for 15 minutes which included Client #1's ISP goals, behavior plan, medication, diet and dining needs, and high risk plans which included Client #1's Diabetic Risk Plan. The facility's nursing services failed to train staff on signs and symptoms of hypo/hyperglycemia other than information contained within the risk plan. On 5/9/13 at 12:33 PM, the Service Coordinator (SC) and the Director of Health Care Services (DHCS) were interviewed. The SC indicated it would be the dietician's responsibility to give the facility guidance on Client #1's 1800 calorie diabetic diet. The SC indicated she did not know why there wasn't a specific menu plan for Client #1. The DHCS indicated the staff might have been trained on how to "exchange" items on the menu but wasn't sure if training forms were completed. An undated, non-client specific "Carbohydrate Serving List" was reviewed but the SC and the DHCS were not able to explain what the list indicated or how staff should use this list to offer diabetic appropriate meals. An "1800 ADA [American Diabetic Association]			

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	calorie diet" form was reviewed on 5/9/13 at 12:56 PM which included a list of "No. [number] of exchanges." The SC and the DHCS indicated they had not seen that form before. The DHCS indicated she would require training from the dietician in order to understand the form. The SC indicated she did not know why staff gave Client #1 a piece of bread at 6:30 AM on 5/8/13 prior to checking his blood sugar and before breakfast. The SC indicated there was no schedule of snacks for Client #1 as far as she was aware. The SC indicated she had trained staff on Client #1's annual ISP (Individual Service Plan) which included his diabetic plan on 3/1/13 but indicated the training did not include specific training on his 1800 ADA calorie diet, menu substitutions, or snacks. On 5/9/13 at 4:57 PM, interview with LPN #1 indicated the staff at Client #1's group home had not been specifically trained on identifying signs and symptoms of high and low blood sugar. LPN #1 indicated the staff received no client specific training for the signs and symptoms of high or low blood sugar. LPN #1 stated it was "inappropriate" for Client #1 to be offered three bowls of grits during breakfast on 5/8/13. LPN #1 indicated an adjustment was made for a			

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	diabetic diet on the April 2013 residential menu but no further menus had been developed. On 5/10/13 at 2:00 PM, Administrative Staff #4 (Developmental Specialist for day services) stated day services staff were trained on the high risk plans but were not trained on specifics on an "1800 calorie ADA diet." The Administrative Staff #4 was not sure whether "ADA" (American Diabetic Association) diet was specified in Client #1's risk plan. Administrative Staff #4 indicated the day service staff were trained on the signs and symptoms of hyper and hypo-glycemia but indicated his staff were not trained on emergency protocol and what blood sugar level for Client #1 would warrant a call to 911. Administrative Staff #4 indicated Client #1's Diabetic Risk Plan does not indicate when to call 911. On 5/10/13 at 3:00 PM, the day service Health and Safety Technician (HT #1) was interviewed and indicated she was unsure of the physician ordered diet for Client #1 but indicated he does not get sweets and only water with lunch. HT #1 indicated day program staff were not trained on any protocol for when Client #1 refuses to eat lunch but she has been documenting his food intake and faxes it to the nurse bi-weekly. HT #1 indicated			

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	Client #1 will usually eat his lunch unless his blood sugar is high. HT #1 indicated Client #1 will usually eat his lunch later if his blood sugar is high. HT #1 indicated she would notify the nurse when Client #1's blood sugar was under 70 or over 200 by writing it down on the sliding scale form. HT #1 indicated she knew to call 911 when Client #1's blood sugar was low but did not know she might need to call 911 if Client #1's blood sugar was too high. 9-3-6(a)			

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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 1 of 3 sampled clients (Client #1) to ensure medications were administered per the physician's orders. Findings include: On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but were not limited to, Diabetes Mellitus, Mental Retardation, Anxiety, Parkinson's Disease, and Hypertension. Client #1's 2/2013 to 5/2/2013 MARs were reviewed and indicated client #1's blood glucose levels were monitored in the AM (morning), Lunch, PM, Bedtime and as needed. The MARs indicated Client #1 was prescribed Novolog 70-30 Flexpen to inject "15 units Sub-Q [subcutaneous injection] 2 times a day (AM and PM) (Workshop Also). Hold if B/S (blood sugar) below 70 and call nurse." The MAR indicated Client #1 had a physician order dated 9/14/10 for sliding scale insulin at lunch time and bedtime. The MAR indicated the following sliding scale was to be administered:	W000368	The client was taken to the ER on 5/9/13 and his blood sugar was brought up to range then he was released. He was then taken to the doctor on 5/14/13 by the Service Coordinator and Community Services Nurse. A full medical assessment was completed. Labs were ordered and his sliding scale was discontinued. Advice was given on modifying his risk plan including but not limited to monitoring blood sugar, signs symptoms and response to high reading, signs symptoms and response to low readings, notifying the Community Services Nurse, when to notifying the physician, accurate use of a sliding scale (discontinued) and the use of Glucerna. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and	06/01/2013

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	-2 units of Novolog if blood sugar (b/s) was between 100-200 -4 units of Novolog if b/s was between 201-250 -6 units of Novolog if b/s was between 251-300 -10 units of Novolog if b/s between 301-400 -12 units of Novolog if b/s was over 400. The MARs also indicated Client #1 had a physician order dated 9/16/10 for one can of Glucerna (used to minimize blood sugar spikes) given three times daily. Review of the MARs and "Site for Subcutaneous Injection Site" form for Client #1 from 2/1/2013 to 5/18/2013 indicated the facility documented administering the sliding scale Novolog but neglected to document the number of units administered on the 2/27/13 (bedtime), 3/1/13 (bedtime), 3/26/13 (bedtime), 3/31/13 (bedtime), 4/23/13 (bedtime), and 5/8/13 (bedtime). Client #1's blood sugar levels recorded on the 2/13 to 5/13 MARs indicated the facility staff administered the wrong number of units of the Novolog sliding scale, per physician orders, for Client #1 on the following dates: 3/10/13 (lunch) staff administered 6 units instead of 4 units for a b/s of 248 4/16/13 (bedtime) staff administered 4		symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.In order to prevent reoccurrence all staff will be trained on the risk plan, this training will include demonstration of reading blood sugars, administering insulin injections via flex pen and use of the sliding scale (if applicable). The client high risk plan was modified on 5/9/13, and again on 5/14/13, and again on 5/22/13. Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. A search for glucometers that allow for uploading of reading will be investigated so readings can be reviewed in real time. In addition, the use of electronic MARS will be investigated with upcoming	

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	units instead of 6 units for a b/s of 281 4/24/13 (bedtime) staff administered 6 units instead of 4 units for a b/s of 247 4/27/13 (lunch) 6 units were administered instead of 10 for a b/s of 303 5/6/13 (bedtime) staff administered 6 units instead of 4 units for a b/s of 243. The record review indicated a Diabetic Risk Plan for Client #1 dated 2/2013. The plan indicated Client #1 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." The plan indicated a nurse would review the MAR (Medication Administration Record) each month. On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services (BDDS) reports and internal incident reports were reviewed and indicated no reported medication errors from 2/1/13 to 5/8/13. On 5/9/13 at 4:57 PM, interview with LPN #1 indicated she reviewed the client's MARs when she visited the group homes, or at the end of the month when they were faxed into the office. LPN #1 indicated she was not aware of any		new software.Until such time that the staff have shown competency in the skills, the nurse will continue to do observations at the home daily. Once competency has been demonstrated, the frequency of visits will decrease to every other day for two weeks then weekly for one month and monthly thereafter.Nursing staff trained staff on existing diabetic diets on 5/9/13 (these plans were not at the home at the time of the survey). As orders have changed and risk plans revised. Additional trainings will be provided. The dietician to make a home visit and develop sample 1800 calorie diabetic menus as guidelines for menu development by 5/22/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home within 2 weeks and will observe a meal and document her observations. Nursing staff began visiting the group home daily beginning on 5/9/13 and began signing in at the home on 5/20/13. Observations have included meal time, medication administration, and documentation review of the MAR, blood sugar readings, and his journal. Nurses have begun training staff on the Supplemental	

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	medication errors. No further documentation which indicated Client #1's residential MARs had been reviewed and/or monitored was available at the time. 9-3-6(a)		Lesson in Core A of Living in the Community, the revised risk plans (as noted above) reading blood sugars, administering insulin injections via flex pen, signs and symptoms of hyper and hypoglycemia and the use of glucerna specifically on 5/9/13. This training and future trainings include modeling the appropriate skills and return demonstrations of the necessary skills. Additional training will be provided as the client's orders change and when new staff enter the house.Additionally, a journal was developed on 5/9/13, staff were trained on it 5/9/13 and it was implemented on 5/10/13 – which includes blood sugar readings, and interventions, intake and applicable behavioral observations. The Community Services Nurse will review this journal daily during their home visit. The Director of Health Services will monitor that the nursing staff is reviewing this information through weekly meetings for three months and then monthly thereafter. Finally, Client #1 continues to see his doctor and specialist. His risk plan will be modified following each visit as necessary and will be distributed to the home and day program with additional training as needed.	

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W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 1 of 2 sampled clients (#1), the facility failed to follow a prescribed 1800 calorie diabetic diet. Findings include: During the 5/8/13 observation period between 5:47 AM and 8:00 AM, at the group home at 7:45 AM, client #1 was served one slice of whole wheat toast, a bowl of grits, 1 small cup of apple juice, a cup of milk and a can of Glucerna (help minimize blood sugar spikes) shake to consume. Once client #1 ate the bowl of grits, staff #2, who was at the table standing near client #1, asked client #1 if he wanted more grits. Staff #2 placed a second serving of grits into client #1's bowl. At 8:47 AM, staff #2 asked client #1 if he wanted more grits. Staff #2 then placed a third serving of grits into client #1's bowl. Client #1 ate the bowl of grits and then drank his Glucerna shake. At 8:00 AM, in the group home's kitchen, a 5/8/13 Menu for a regular diet was posted next to the refrigerator. The group home did not have an 1800 calorie diabetic diet menu posted. The 5/8/13 menu indicated	W000460	As doctor's orders are revised the dietician will adjust Cl#1 1800 calorie diabetic menus as guidelines for menu development by 5/21/13. The client's diabetic diet plan will be revised. In order to prevent reoccurrence the dietician will train both home and day program on the risk plan, this training will include a demonstration on making exchanges and identifying appropriate day time snacks. Following this training the dietician will visit the home within 2 weeks and will observe a meal and document her observations. In addition, the Service Coordinator, Nurse and Area Manager will visit the home at least weekly to observe a meal.	06/01/2013

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	clients were to receive apple juice, 1 bowl of grits and a slice of toast. During the 5/8/13 observation between 11:11 AM and 12:28 PM at day service program, At 11:11 AM, Client #1 was observed sitting at a table for lunch. Client #1 had sausage pizza broken up into pieces, salad with Italian dressing and a cup of water. Staff #6 indicated Client #1 had already eaten his french fries around 11:00 AM. Client #1 was observed to return to his day service room. At 11:15 AM, Staff #7 was observed to take Client #1's lunch plate from the microwave and offer it to him. Client #1 refused to eat anymore of his lunch. Client #1 kept his cup of water with him and continued to drink the water. At 11:22 AM, Client #1 was observed to refill his glass of water at the sink independently and then sit on the couch. At 11:50 AM, Client #1 was checking door knobs to straighten them and picking lint off carpet and eating it. At 11:56 AM, Client #1 was observed sitting on the couch holding his cup of water and drinking his water throughout the observation. At 12:02 PM, the client's diet roster was observed taped to a cabinet. The diet roster indicated Client #1 was on a "NCS" (No Concentrated Sweets) diet. At 12:24 PM, Client #1 was offered another lunch plate which he			

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	refused to eat. On 5/7/13 at 11:53 AM, the Bureau of Developmental Disabilities Services (BDDS) reports and internal incident reports were reviewed and indicated the following: -A BDDS report dated 2/13/13 indicated on 2/9/13 staff reported Client #1's disposition had changed and his blood sugar was checked. Staff reported Client #1 did not want eat and did not seem as active as usual. The report indicated Client #1's blood sugar was above the recommended level and the nurse instructed staff to take Client #1 to the hospital "immediately." The report indicated Client #1 was admitted to the hospital for high blood sugar and "a stomach infection which may have caused his sugar to raise." An internal incident report dated 2/9/13 indicated Client #1 had been reported sick the previous day on 2/8/13. The report indicated Client #1's "vitals were extremely abnormal, he was not eating or drinking." The report indicated Client #1 was taken to the hospital. On 5/9/13 at 2:39 PM, the nurse emergency call log dated 2/9/13 indicated Client #1's blood sugar was in the 300's with irregular vitals prior to being admitted to the emergency			

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	room. -An incident report summary sheet dated 3/14/13 indicated Client #1 was drinking milk when his body motion became "unusual." The report indicated Client #1 began "twisting" and was about to fall out of chair. The report indicated staff called 911 and then the nurse. The report indicated Client #1 refused to go with the paramedics to the hospital and they waited for Client #1 to eat before they left. On 5/9/13 at 2:39 PM, review of the nurse emergency call log dated 3/14/13 indicated Client #1's blood sugar was 52 before the paramedics had arrived. -A BDDS report dated 4/19/13 indicated Client #1's blood sugar dropped to 30 at 3:45 PM. The report indicated staff attempted to give Client #1 soda but he got on the floor, curled up, and would not eat or drink. The report indicated Client #1 was transported to the hospital. On 5/9/13 at 2:39 PM, review of the nurse emergency call log indicated Client #1 was discharged from hospital after a blood sugar level of 32 and a diagnosis of urinary tract infection. -A BDDS report dated 4/25/13 indicated on 4/24/13 at 7:30 PM, Client #1 was out in the community shopping when he "appeared weak" and staff supported him			

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	to the ground. The report indicated an ambulance was driving by and was asked to assist. The paramedics checked Client #1's blood sugar which read 174. The report indicated staff began to take Client #1 home in the van when he began shaking. The report indicated the paramedics were located and took Client #1 to the hospital where he was checked and released the same day. During interview on 5/9/13 at 5:35 PM, the Behavioral Specialist indicated Client #1 was in an ambulance on his way to the hospital due to low blood sugar levels. On 5/9/13 at 2:19 PM, a record review for Client #1 indicated client #1's diagnoses included, but was not limited to, Diabetes Mellitus. The record review indicated a Diabetic Risk Plan for Client #1 dated 2/2013. The plan indicated Client #1 was at risk for "having overly high or low blood sugar levels and the health concerns that come with poorly controlled Diabetes." Client #1's 2/2013 to 5/2/2013 MARs indicated client #1's blood glucose levels were monitored in the AM (morning), Lunch, PM, Bedtime and as needed. The MARs indicated Client #1 was prescribed Novolog 70-30 Flexpen to inject "15 units			

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	Sub-Q [subcutaneous injection] 2 times a day (AM and PM) (Workshop Also). Hold if B/S (blood sugar) below 70 and call nurse." The MAR indicated Client #1 had a physician order dated 9/14/10 for sliding scale insulin at lunch time and bedtime. Client #1's updated Annual Nutritional Assessment dated 4/2013 indicated Client #1's diet was changed to a diabetic 1800 calorie diet with the Glucerna shakes three times daily. Interview with staff #2 on 5/8/13 at 8:04 AM stated client #1 was on a "diabetic diet." When asked where the diet was posted, staff #2 could not locate the diabetic diet. Staff #2 then went to the staff's office and stated client #1 was on an "1800 calorie diabetic diet." Staff #2 had an April 2013 Menu which had 1800 calorie Diabetic diet written in red ink at the top of the menu. Staff #2 indicated client #1 could have what was written on the regular menu unless something was written in red by the menu item. The facility's posted May 2013 regular menu did not have any red notations on the 5/13 menus for the month of May. When asked what menu staff #2 followed for client #1 at the breakfast meal, staff #2 indicated she followed the posted menu in the kitchen.			

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	Interview with staff #3 on 5/8/13 at 8:15 AM indicated client #1 was diabetic and was on an 1800 calorie diabetic diet. Staff #2 indicated the posted menu in the kitchen was for a regular diet. When asked what client #1 was to receive since he was on an 1800 calorie diabetic diet, staff #3 stated "We just know what he should have." Staff #3 indicated staff did not assist client #1 to measure his food/servings. Staff #3 stated "He does not have to measure it out. We do by sight." Staff #3 stated the group home was using "an exchange." Staff #3 stated "One slice of bread equals 1 cup." Staff #3 indicated client #1 should not have received 3 bowls of grits at the breakfast meal. An interview on 5/8/13 at 12:15 PM with Staff #6 indicated Client #1 used to bring his lunch from home but he wouldn't eat it. Staff #6 indicated the day service staff tracked how much Client #1 ate throughout the day. Staff #6 indicated Client #1 usually ate his lunch unless his blood sugar was high during which case they offered Client #1 his lunch later. On 5/9/13 at 12:33 PM, the Service Coordinator (SC) and the Director of Health Care Services (DHCS) were interviewed. The SC indicated it would			

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	be the dietician's responsibility to give the facility guidance on Client #1's 1800 calorie diabetic diet. The SC indicated she did not know why there wasn't a specific menu plan for Client #1. The DHCS indicated the staff might have been trained on how to "exchange" items on the menu but wasn't sure if training forms were completed. An undated, non-client specific "Carbohydrate Serving List" was reviewed but the SC and the DHCS were not able to explain what the list indicated or how staff should use this list to offer diabetic appropriate meals. An "1800 ADA [American Diabetic Association] calorie diet" form was reviewed on 5/9/13 at 12:56 PM which included a list of "No. [number] of exchanges." The SC and the DHCS indicated they had not seen that form before. The DHCS indicated she would require training from the dietician in order to understand the form. The SC indicated there was no schedule of snacks for Client #1 as far as she was aware. On 5/9/13 at 4:57 PM, interview with LPN #1 indicated client #1 was an insulin dependent diabetic. LPN #1 stated it was "inappropriate" for Client #1 to be offered three bowls of grits during breakfast on 5/8/13. LPN #1 indicated an adjustment was made for a diabetic diet on the April 2013 residential menu but no further menus had been developed.			

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